February, 1958

Canadian Hospital

- *A symposium on rehabilitation medicine*
- *The hemiplegic in hospital*
- *A new rehabilitation centre*
- *A dietary consulting service*

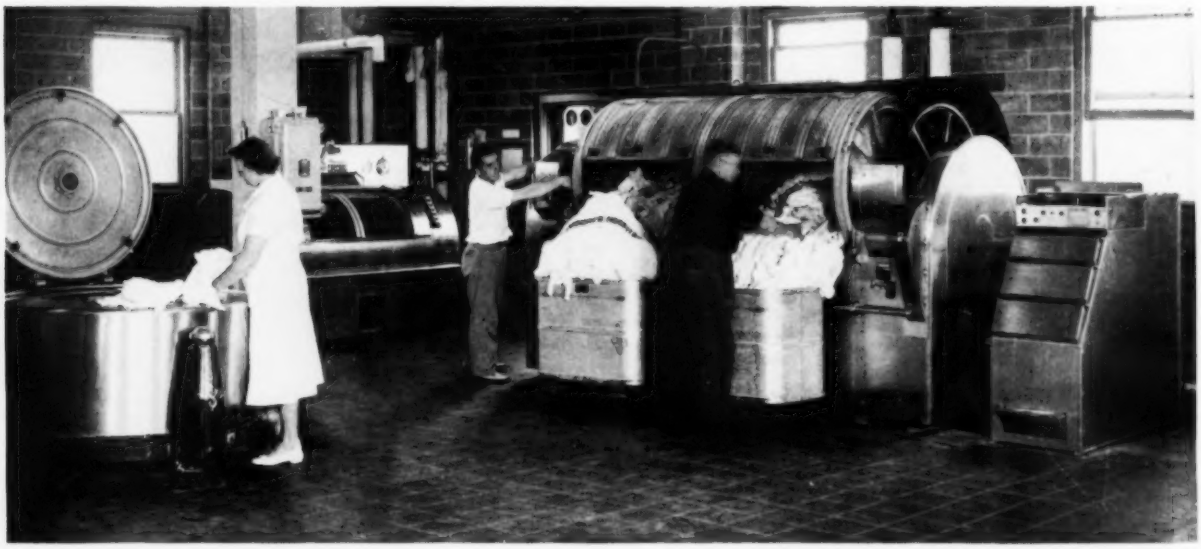
Canadian Hospital Association

HERE'S WHAT TODAY'S LAUNDRY LOOKS LIKE IN A 150-BED HOSPITAL

New St. Joseph's Hospital, Brantford, Ontario, is proud of its up-to-date laundry department. Most efficient use of floor space, carefully planned work flow and modern labor-saving Canadian Laundry Machinery Company equipment assure high-quality, low-cost laundering of all hospital linens and garments and their fast return to service.

Canadian Laundry Machinery Company's hospital laundry consultants worked closely with St. Joseph's Hospital's architect. Canadian Company engineers made a thorough survey of the hospital's clean linen requirements, then recommended laundry machinery best suited to meet the need, prepared detail drawings and floor plan layouts and supervised the installation of equipment.

This same laundry planning service is available to your hospital without obligation. Talk to your Canadian Laundry Machinery Company representative about the benefits to be obtained by modernizing your laundry department, perhaps just several machines at a time. Ask him to show you our new motion picture, "Within These Doors," on hospital laundry planning and operation.



The main reason why *fewer* people do *more* work in St. Joseph's Hospital's laundry department is the Cascade Unloading Washer with Cascade Automatic Control shown above, at right. At the touch of a button, 350 lbs. of hygienically washed work are automatically unloaded in less than a minute. The Cascade Automatic Control performs all operations of the complete washing cycle without operator attention. Other washroom equipment shown includes a 165-lb capacity Cascade Washer and Monex O. T. Extractor.

This unit of push-button-operated Super-Zarmo and Super-Zarmoette Presses quickly machine-finishes hospital uniforms and other garments, so that hand touch-up is seldom necessary. In left background is Zone-Air Tumbler with drying capacity of 300 lbs. per hour for work that is not ironed.

This 4-Roll Super-Sylon Flatwork Ironer with Airvent Canopy beautifully irons all hospital linens, speeds up work flow to keep pace with the high production of the washroom.

Canadian

The Canadian Laundry Machinery Company, Ltd.
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you can fluoroscope conventionally on a full size 14" X 14" screen for general exploration (for example, observing the entire esophagus while the patient swallows, or visualizing the whole colon or lung field).

you can instantly intensify the image of any local area (up to 5" diameter) by simply pushing the screen back and sliding the amplifying element over. Or do cinefluorography at will with the permanently-mounted camera (optional) seen here.

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- conventional fluoroscopy on a full-size screen
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you can employ any of these technics at any time because everything you need lies permanently within easy reach on the fluoroscopic deck.

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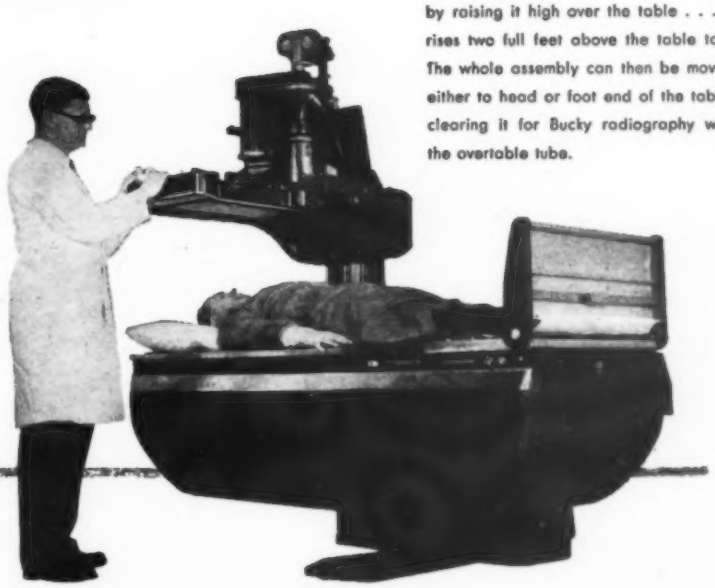
Your local Picker man has a 10-minute "movie" on the Amplifilmer. Let him show it to you.

you can instantly park the Amplifilmer by raising it high over the table . . . it rises two full feet above the table top. The whole assembly can then be moved either to head or foot end of the table, clearing it for Bucky radiography with the overtable tube.



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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
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(For Subscription Rates see page 92)

Business Manager: Charles A. Edwards
Advertising Manager: Thomas L. Wells

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PHYSICAL MEDICINE

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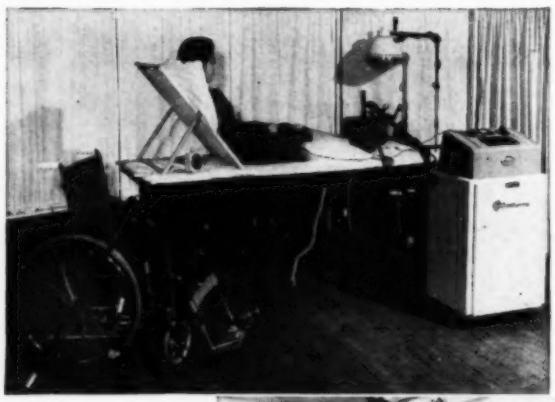

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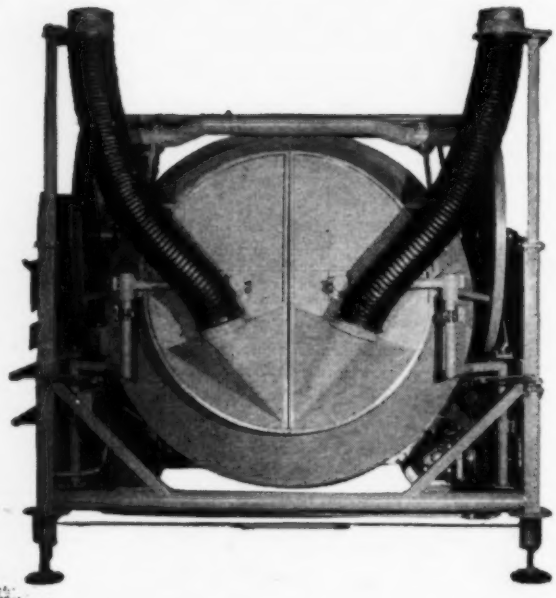
PURKETT'S *New 25*-ring 72-inch Pre-Drying Conditioning Tumbler

Gives 4 lbs. Moisture Removal per Minute



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DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

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Notes About People

New Head at Jordan Sanatorium

The appointment has been announced of Dr. Arthur R. F. Adams as superintendent of the Jordan Memorial Sanatorium, The Glades, N.B. Dr. Adams has, since 1954, been assistant medical superintendent of the Moncton Tuberculosis Hospital, Moncton, N.B., where he had been on staff since coming to Canada in 1948.

Dr. Adams qualified from the Irish School of Medicine in 1937, and subsequently spent two years in post-graduate medical training with a view to specializing in tuberculosis. During his war service years with the navy, Dr. Adams visited Canada and decided upon it as his future home.

Dr. George H. Blennerhassett, a former senior physician at the Middlesex County Sanatorium, Waltham, Mass., has taken up the duties of medical superintendent at the Moncton Tuberculosis Hospital, succeeding the late Dr. P. M. Knox.

Dr. W. Cormier Named Medical Director

Dr. Wilbrod Cormier has been named medical director of the Saint - Louis - Marie - de - Montfort Hospital, Ottawa, Ont. After graduating from Laval University in 1943, and a three year stint of military service, he continued his medical studies in phtisiology and pulmonary illness. Since 1951 he has been chief medical officer at the Ross Sanatorium at Gaspé, Que.

Sackville Superintendent

Geraldine R. Smith, R.N., will be the new superintendent of the Sackville Memorial Hospital, Sackville, N.B., after April 30, 1958. She will succeed Jeannie S. Murdoch, recently married, who will leave on that date.

Miss Smith, a native of New Brunswick, graduated from the school of nursing at the Saint John General Hospital in 1944, and worked for two years on the staff of the Victoria Public Hospital in Fredericton. In 1956 she was obstetrical supervisor at the Sackville Memorial Hospital and in 1957 took on the additional duties of assistant superintendent. She is also a founder member and past president of the Sackville Nurses' Club.

New Administrator

Donald M. McIntyre has taken up his new post as superintendent at Kingston General Hospital, Kingston, Ont. He succeeds R. Fraser Armstrong, who retired after 31 years of service there.

Mr. McIntyre is succeeded in his Kitimat post by D. S. Gray, who has been assistant administrator there for the past two years. He is a graduate of commerce and also holds a diploma in hospital administration from the University of British Columbia. Mr. Gray was formerly special assistant to the administrator of the Trail-Tadanac Hospital, Trail, B.C.

Nursing Superintendent at Castlegar

New superintendent of nursing at the Castlegar and District Hospital, Castlegar, B.C., is Mary R. Higgens, R.N. Mrs. Higgins is a graduate of the Kelowna General Hospital's school of nursing, Kelowna, B.C., and was matron of the Michel Hospital, Michel, B.C., prior to 1954. She has also been matron in the Victorian Hospital of Kaslo, B.C.

W. C. Hibbert Resigns

W. C. Hibbert, superintendent of the Wadena Union Hospital, Wadena, Sask., since 1949, has resigned his post to take up the duties of administration officer of health services at the Indian hospital at North Battleford, Sask. He is succeeded by Ian McLean.

Alberta Hospital Officials Organize New Group

Dr. Irial Gogan, medical director of the Holy Cross Hospital, Calgary, Alta., has been elected chairman of the newly formed Calgary Regional Hospital Conference. Dr. J. C. Johnston, administrator, and E. M. Forbes, administrative assistant of Calgary General Hospital, will serve as vice-chairman and secretary, respectively.

The group, formed of administrative personnel of all Calgary hospitals, will study hospital problems in their broadest aspects as well as individual hospital problems and needs.

Medical Director Appointed

Dr. Victor H. Radoux is the new medical director at the Hotel-Dieu de Québec, Quebec City, Que. Dr. Radoux served for 15 years in the Canadian army, and has completed the course in hospital administration at the University of Toronto. He succeeds Jean-Baptiste Jobin.

• Dr. John G. Howlett of McGill University and the Royal Victoria Hospital, Montreal, Que., has been appointed chief of the department of medicine at St. Mary's Hospital in Montreal. He succeeds Dr. Gordon J. Cassidy.

• Ethel Brown, R.N., has been named superintendent of the Fishermen's Memorial Hospital, Lunenburg, N.S. She succeeds Mrs. LeVerne McEachron.

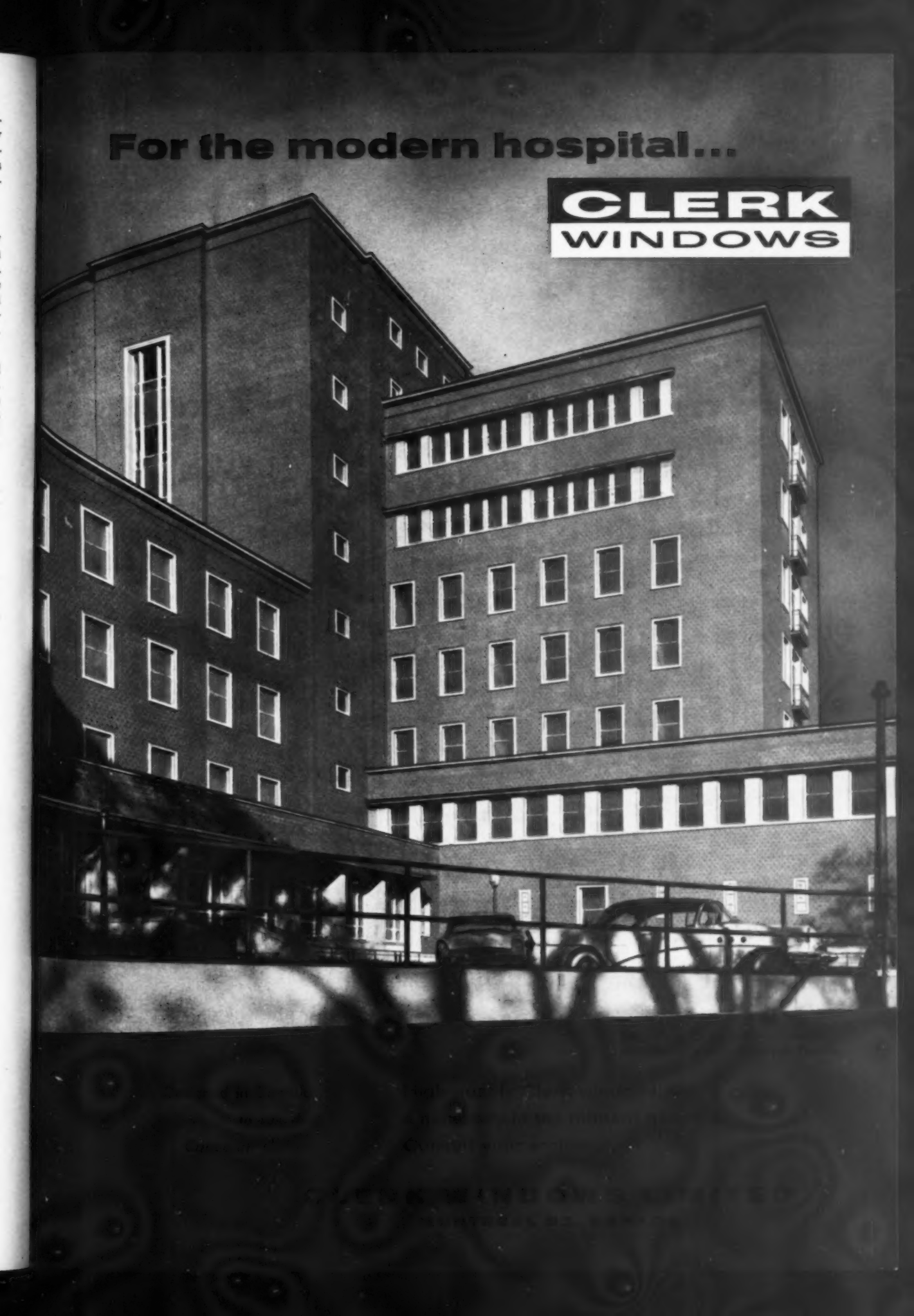
• Dr. David Kubryk, formerly hygiene officer for the Quebec Command of the Canadian Army, has joined the epidemiology division of the Department of National Health and Welfare as a medical officer.

• R. P. Kopciuk, formerly an enrollment representative with the Manitoba Blue Cross, has been appointed as supervisor of enrollment in north-western Manitoba.

Art Therapy

Form and colour are dissipating the nervous tension and anxiety of physically and mentally disabled patients at veterans' hospitals all across Canada. At Shaughnessy Hospital, Vancouver, B.C., where it was introduced by Dr. Eric Loewe in 1947, the results of this technique, proudly displayed at their 4th Annual Art Exhibition of Art Therapy, were so remarkable that some of the work is actually of commercial value.

Under the direction of competent therapists the patients are encouraged to take up brush and oils. Even those who have lost the use of all limbs are able to enjoy this means of self-expression by holding the brush or a crayon between their teeth. The value of art therapy in offsetting frustration and discouragement is attracting ever-increasing attention to "Art for Health's Sake".—*Canadian Services Medical Journal.*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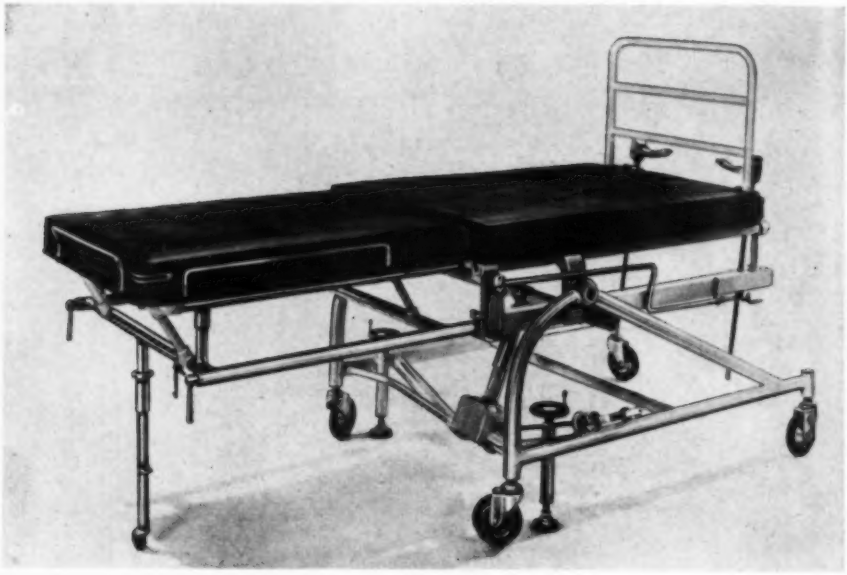

the versatile

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This unique bed was recently designed in close collaboration with the famous Liverpool Maternity Hospital because of the urgent need felt, and expressed, for improvements in the design of conventional beds. Old-type beds are not suitable for much modern operative obstetrics, and they take up a great deal of nursing time and energy.

The Elliott Obstetric Bed incorporates all the principles of the **ideal** labour and delivery bed. It is comfortable. It possesses every device necessary to facilitate the handling and moving of the patient for any operative procedure. For delivery the foot end retracts easily under the main section. It is light and mobile. No detachable parts require storage elsewhere. An adequate Trendelenburg position is available.

Send for copies of the fully-illustrated explanatory pamphlet which shows the bed in every state of use.

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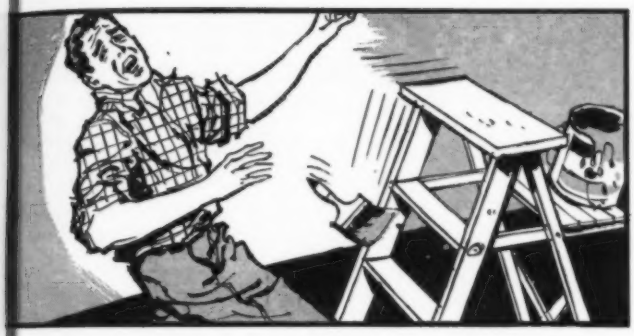

11.00 a.m. Andy, a do-it-yourselfer—who shouldn't —sustains colles fracture, requiring immediate attention.

11.45 a.m. Neraval, ultra-short acting intravenous barbiturate, is administered. Less respiratory depression observed than with other thiobarbiturates.

1 p.m. **Recovery Room:** Andy's return to full consciousness at 12.30 p.m. attributable to Neraval's lower milligram potency and more rapid metabolism. Able to eat light lunch at 1 p.m.

4.00 p.m. Completely recovered, without "hangover", Andy is homeward-bound, thanks to ultra-short acting Neraval.

... Neraval, a new ultra-short acting barbiturate for intravenous anesthesia, is the first important advance in intravenous thiobarbiturates in nearly 25 years. Rapid recovery makes Neraval an ideal agent for use in all procedures where it is desirable to discharge the patient on the same day. Research studies with Neraval in obstetrics indicate that there is no depression of respiration in the newborn. Its excellent tolerance in the very young and very old has been recognized by all clinical research investigators.

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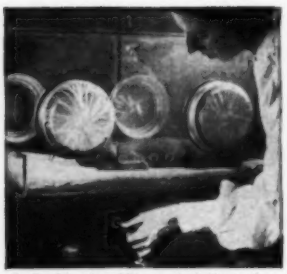
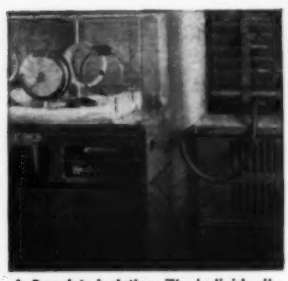
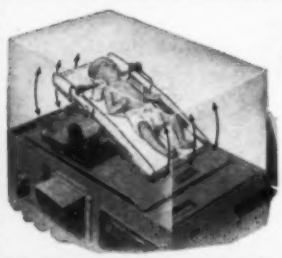


3. Positive humidity control through a single setting of a simple control valve. Constant, controlled recirculation maintains relative humidity at optimal level, as high as 85% to 100%.



4. Complete isolation: The individually air-conditioned ISOLETTE® uses fresh, outside air . . . protecting the infant from air-borne pathogens and droplet infection from the nursery.



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Write for information
the **ISOLETTE® ROCKER**
for Non-traumatic Treatment
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Atomic Upset?

Atomic power is news today in all parts of the world; everything concerned with it provokes an emotional reaction on the part of the public. The mental health problems which arise when this reaction takes the form of irrational fears and irrational hopes have been reviewed by a study group of the World Health Organization (WHO) under professor Hans Hoff of Vienna. In this group were representatives of psychiatry, atomic and radiation medicine, public health, social anthropology, and journalism.

In reports from many countries of the emotional impact of atomic energy developments on everyday life, public statements, the press, letters from public leaders, the group found that irrational fears were expressed more often than irrational hopes. This may be because people first heard of radiation in relation to cancer and tuberculosis—two dreaded diseases. Then atomic energy was used as a weapon, arousing fear, and often moral involvement and guilt.

A mysterious, almost magical aura surrounds atomic power and is reflected in public attitudes. Atomic radiation, it seems, is invisible, unheard, unfelt, apparently infinitely powerful yet springing from an almost infinitely small source, and to ordinary people, it appears uncontrollable. Its credited potentiality for both good and evil represents man's most amazing success in his search for power, but man's oldest legends show how often this quest for human power has resulted in terrible divine punishment. For stealing fire from the gods Prometheus suffered eternally. And how is man to control this power? People fear a biological chain reaction — fallout and atomic wastes that would poison air, water, and soil, then plants, cattle, the men who eat these poisoned things, and most important of all, their descendents. The fears are interwoven but subtely powerful.

Unreasonable hopes affected people, it was reported, in both developed and undeveloped countries. Many people expect immediate returns from atomic energy in prestige, amenities, and finally a higher standard of living, for the poorer countries. They press urgently for these benefits and they are disappointed. New ways of life and many technical skills will be needed for these improvements. In this difference between aspirations and results which turn hope into hostile bitterness lies a real danger to world peace, the group felt.

The study group also found a spreading mistrust of information sources. Wars, psychological warfare, political propaganda, science fiction, and even competitive commercial advertising have contributed to this mistrust. The publicizing of disagreements among scientists — about the cancer-producing effects of smoking, for example—has lost for science the infallibility with which it was credited in the 19th century. Distrust of scientific announcements has become a serious obstacle to public confidence in the peaceful use of atomic power.

The group considered the common feeling that there are no mental health, or even moral as-

(concluded on page 24)

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The highly elastic compression bandage for long lasting use

The Rubberthread Bandages
DURELASTIC DE LUXE

- possess an excellent compressive action when applied in case of injured joints or of venous stasis in the legs
- can be worn for weeks and months without losing their elasticity
- may be washed frequently and even boiled at times
- hold fast – do not slip

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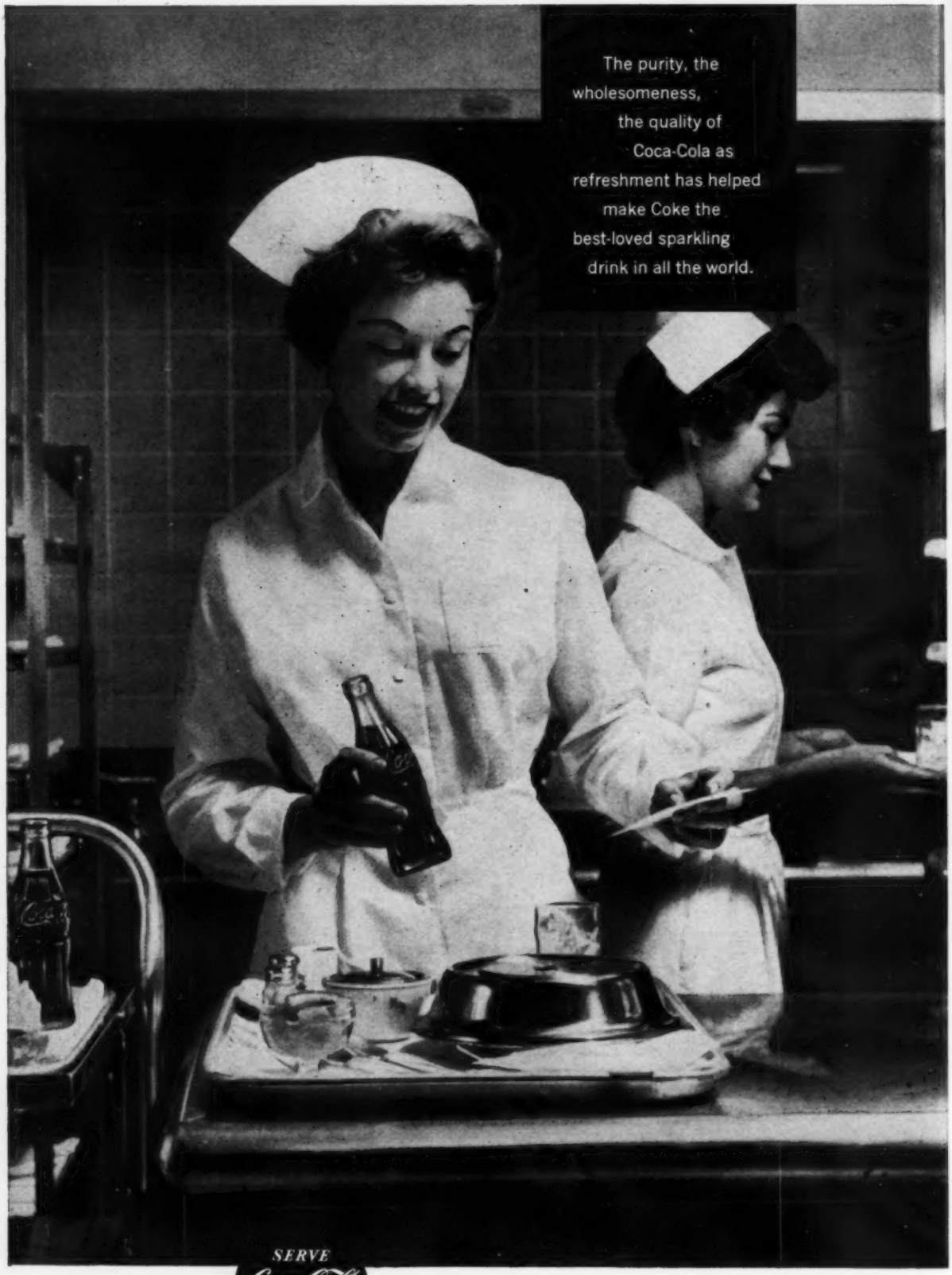

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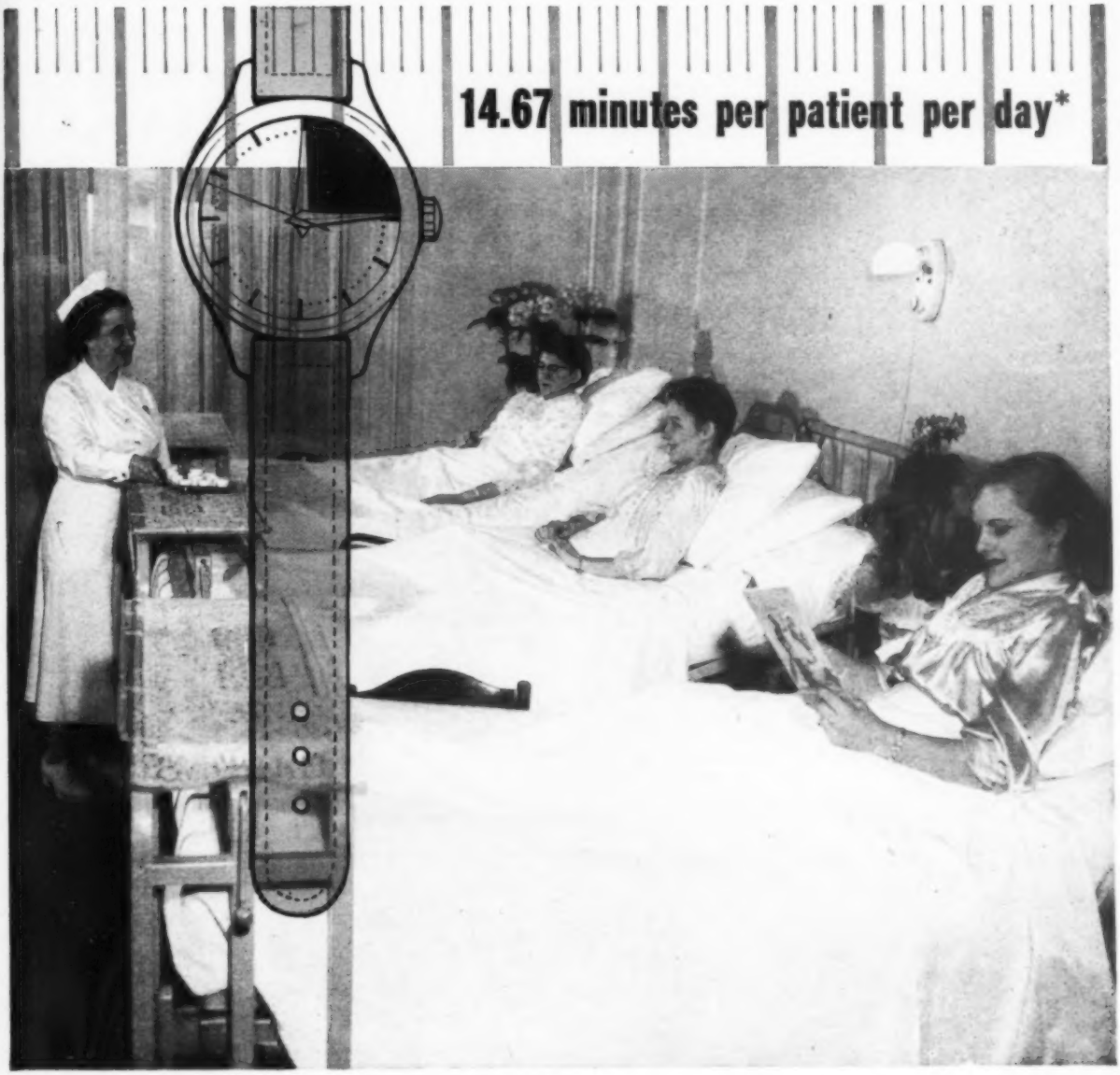

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*"The substitution of the capsule (Eskabarb† 'Spansule') for q.i.d. medication resulted in a saving of 14.67 minutes per 24 hour day per patient."[1]

1. *E. G. Gooby and D. R. Turnbull: New Technic of Administering Medications, THE CANADIAN NURSE, (August) 1957.* †*Reg. Can. T.M. Off.*

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New *Curity* Adhesive unwinds with the same gentle pull right to the very end of the roll. No more wasting the last couple of feet because you can't get it off the roll. And—***Curity*** stays fresh.

New *Curity* Adhesive is easy to apply—and it sticks! Won't wrinkle or tangle—because it has proper "body". It's up to 53% stronger than USP requirements—yet even the tiniest student nurse can tear it.

New *Curity* Adhesive is easy to remove—and it comes off clean. (No sticky mass left on skin.) You can't put a less irritating adhesive on a patient.

Since the invention of adhesive tape, manufacturers have been faced with the problem of making a tape that was easy to handle yet would really stick.

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What's more, these balanced properties are built in to stay: a roll that's been in your drawer six months is just as fresh as one right from the factory.

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You get these new qualities in every roll of Curity adhesive you buy.

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when this TROY unloading washer goes to work

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HOSPITAL

ADDRESS

CITY ZONE STATE

ATTENTION MR.

Atomic Upset

(concluded from page 18)

pects of atomic energy as a sign of anxiety. Avoidance of the subject, they felt, shows that rational thought is sometimes blocked by emotions, and could lead to over-confidence. Reactions varied from acute fear, to conscious apathy, to pooh-poohing or making fun of the whole situation, but the group found that atomic energy always provoked some reaction.

The complexity of emotions in the changing environment of the atomic industrial revolution, the group felt, should be recognized more widely by public leaders. Better understanding of the situation would enable the re-orientation to take place without upheaval. On the local level, small teams could be formed consisting of a psychiatrist, a psychologist, a sociologist, and a journalist, to study local conditions, help plan atomic enterprises, and educate the public. Scare headlines could be avoided if journalists understood the implications of the news they had to handle.

The group was also convinced that although its findings were in no way alarming, they were concrete enough to warrant the attention of those in authority. Their study showed that the behavioural sciences can contribute to making atomic power a benefit by adapting the world to the new power. — *Pan American Sanitary Bureau, WHO.*

Heart Research in Montreal

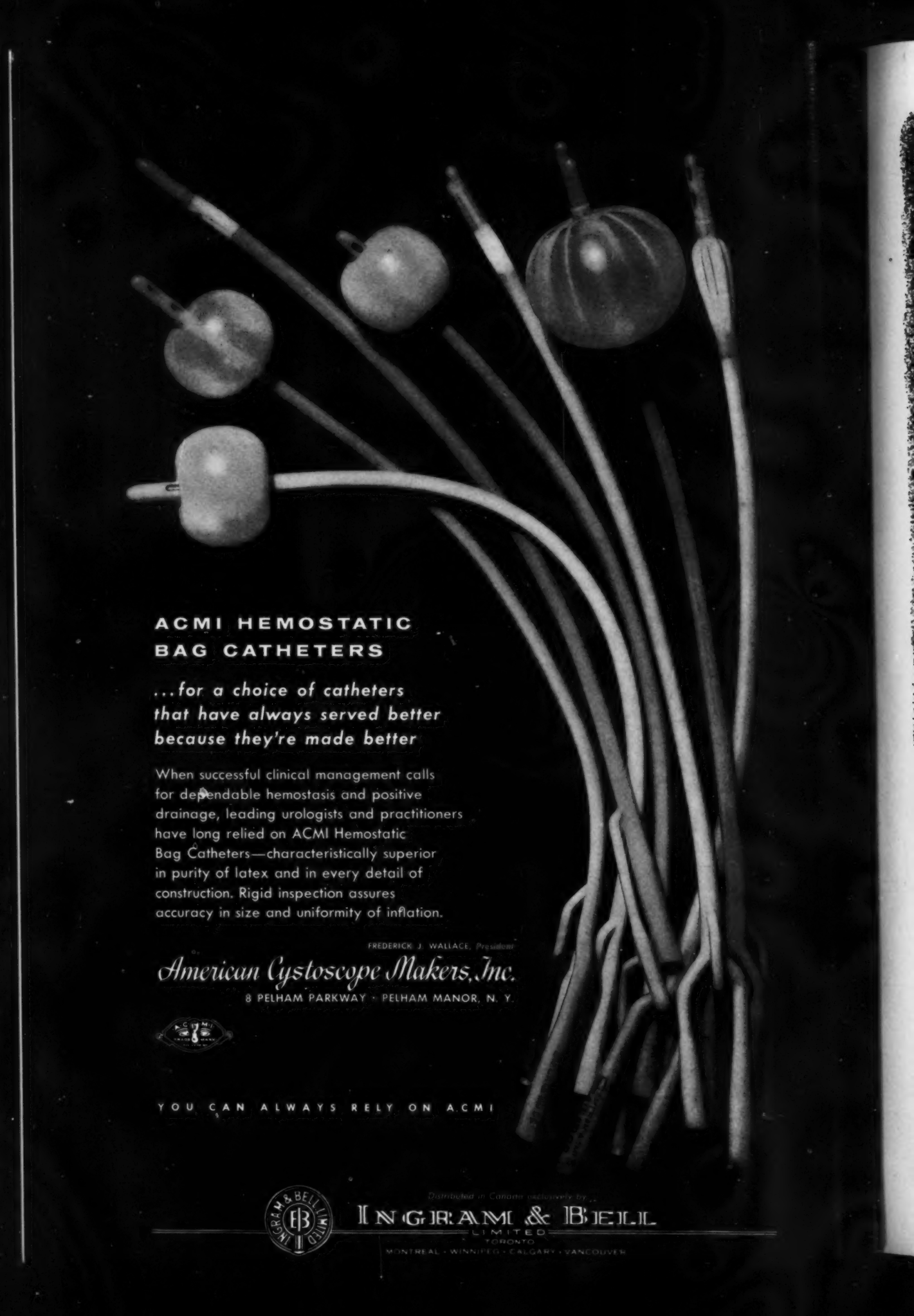
As a joint undertaking, the Royal Victoria Hospital and the Montreal Children's Hospital are establishing a heart research and treatment centre for Montreal to provide exceptional opportunities for giving medical services to persons in that part of Canada suffering from diseases of the heart, arteries, and respiratory organs. Facilities will also be available for training doctors in the newest techniques and for research into improved methods of treatment. Both children and adults are to be cared for when the centre is fully staffed and operating. It is expected to open within a year.

Research will be started immediately to assess in the laboratory recent advances in heart disease treatment, including the use of an artificial heart-lung apparatus. This work, directed by David R. Murphy, M.D., surgeon-in-chief and director of cardiovascular surgery for the Children's Hospital, will be carried out in the experimental surgery laboratory of McGill University and at the Children's Hospital. About $71,600 has been granted by the federal government to assist this project, and approximately $60,000 of this sum will be used for intricate scientific equipment and supplies required for the diagnosis and treatment of heart diseases.

C.S.R.T. Convention

When the Canadian Society of Radiological Technicians holds its annual convention in Winnipeg, Man., in June it will have four busy days. In the morning from eight until ten there will be refresher courses. Business sessions will carry on until noon. In the afternoon technical papers will be presented, and there will be instruction in both radiodiagnosis and radiotherapy.

The wrong way always seems most reasonable.—*George Moore.*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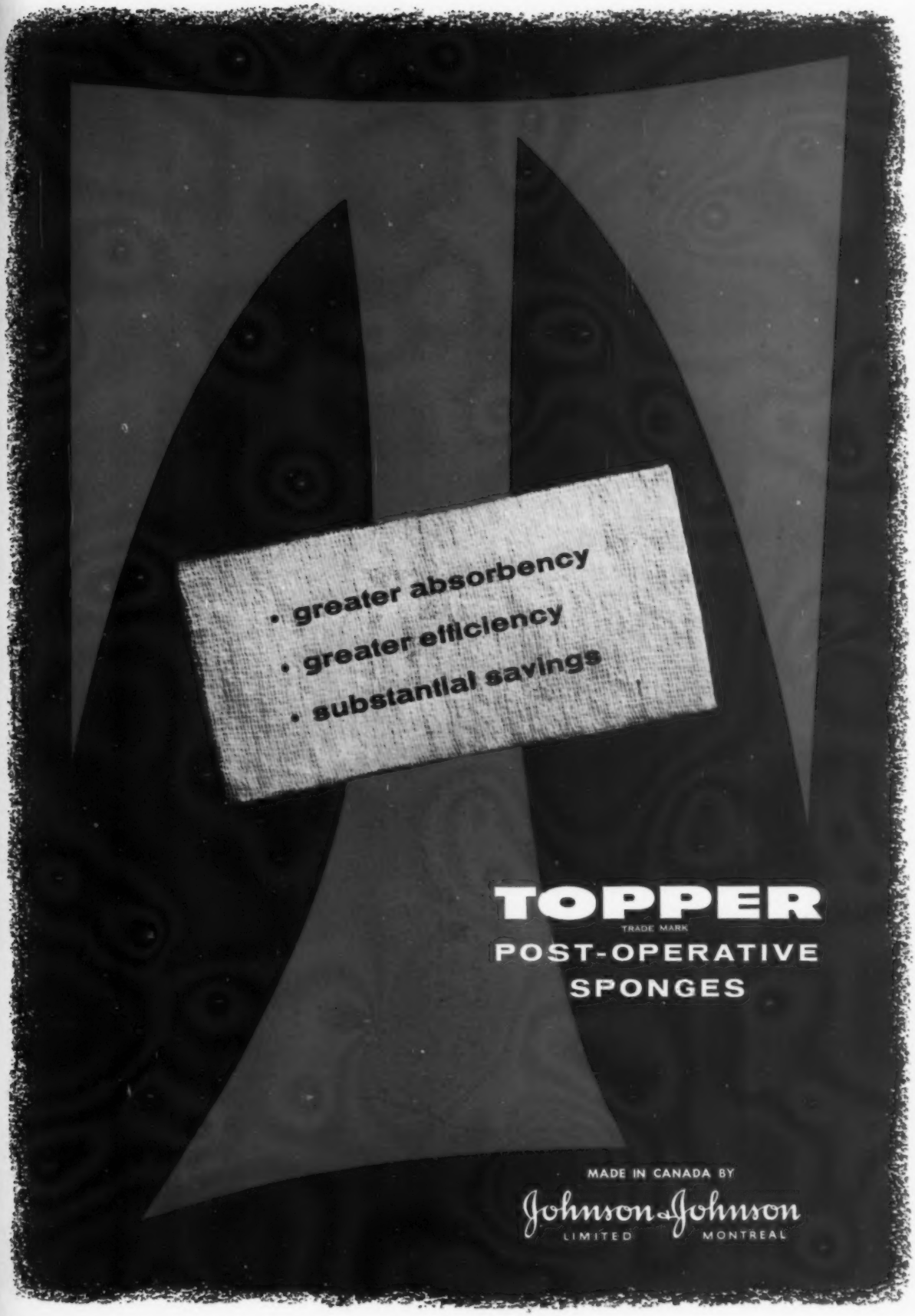
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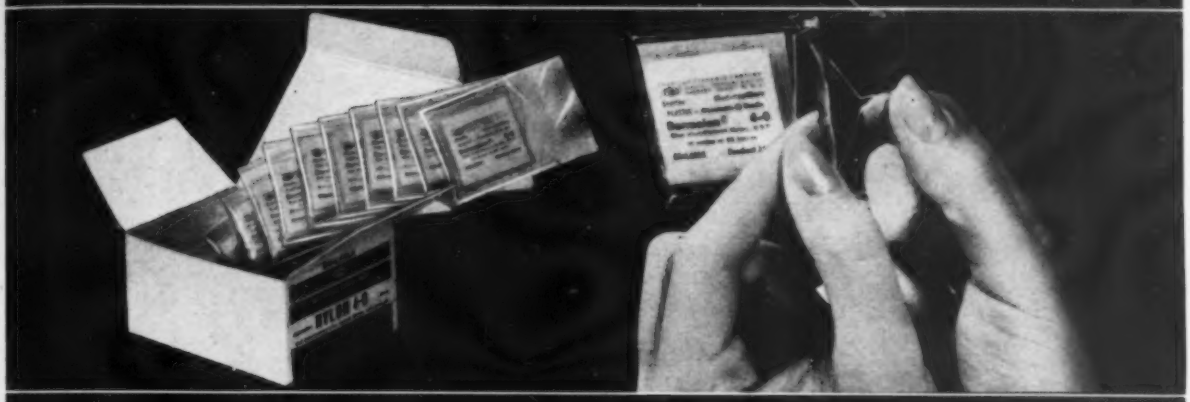

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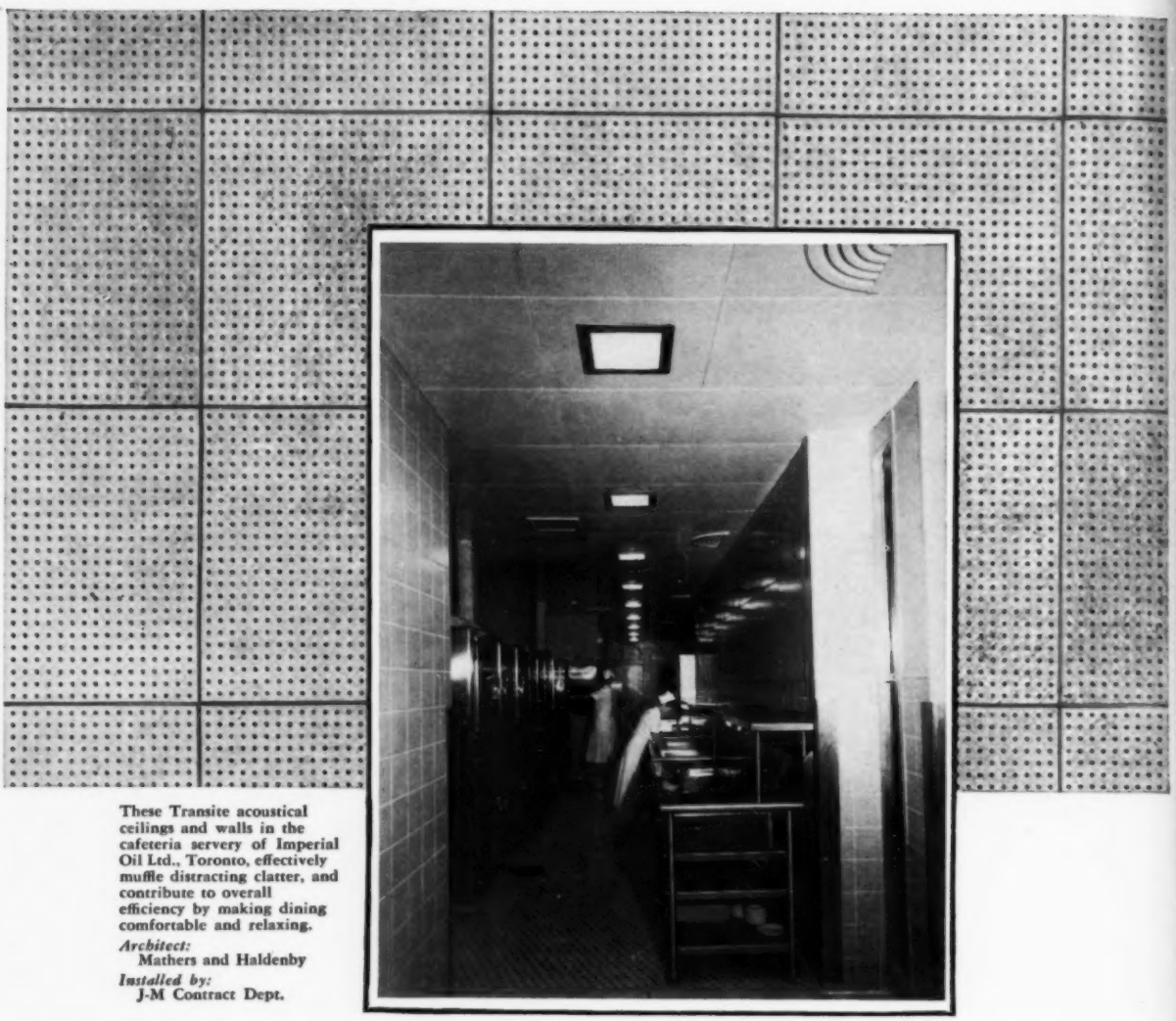

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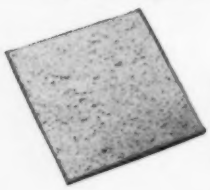

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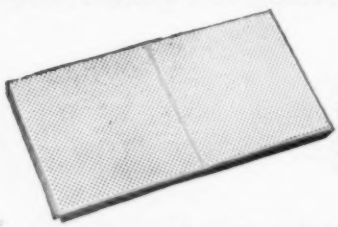

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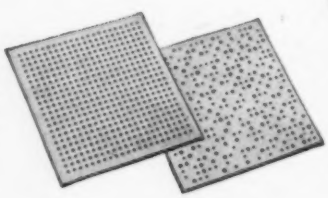

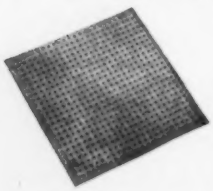

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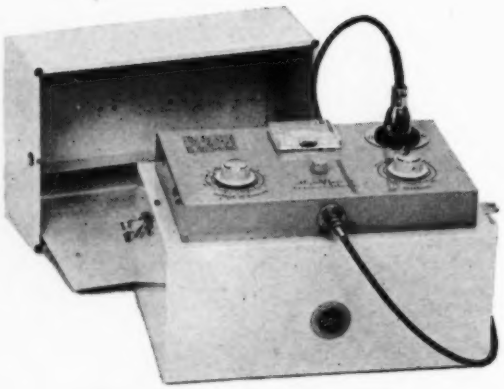

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Obiter Dicta

Rehabilitation in General Hospitals

THE idea has been growing rapidly that rehabilitation services should be provided for many patients in general hospitals. While the word 'rehabilitation' has been used with varying meanings it has come to be interpreted generally as a third phase of medicine. It is a broad concept of recovery which includes diagnosis, treatment and motivation of the whole patient with ultimate restoration in view. Rehabilitation services bridge the gap between the patient in the hospital bed and his job in the community. Thus, the best medical treatment has rehabilitation of the individual as its final aim. Without this a half cure is all that many patients receive while in hospital. Interest in the patient today should not stop at the hospital door; we have to look beyond the illness and consider him as an individual in relation to his family, his work, and the community in which he lives.

It is the aim of rehabilitation programs to restore all disabled persons to their maximum usefulness within the limitation of their handicap. One example is the effort to restore the disabled housewife so that she can again undertake her household duties. There is much that can be done in this single area if she receives adequate re-education, and if attention is given to arrangements in the home.

Nowhere in the hospital is the team approach to patient care better exemplified than in rehabilitation. Many groups with various backgrounds, education, and technical skills are required. Many national and local organizations, both voluntary and governmental, carry on rehabilitation programs. Many phases of these projects are linked with the general hospital. What one hospital is currently doing in this field is described in this issue. We believe the report of the University of Alberta Hospital's new rehabilitation department and the related symposium which was presented at the recent meeting of the Associated Hospitals of Alberta will be read with widespread interest.

Inter-professional Liaison

THE function of the Canadian Joint Committee on Nursing is to provide a liaison between three national bodies,—the Canadian Medical Association, the Canadian Nurses' Association, and the Canadian Hospital Association. Meetings are held periodically for an exchange of views and information.

At the session held in Toronto, January 20th, recommendations made by the first Canadian Nursing Conference, held in Ottawa in November, 1957, were examined. As considerable confusion exists regarding the meaning of the term "independent school of nursing", the joint committee explored the many implications in the use of this term and attempted to reach an understanding of its meaning as used by the Canadian Nurses' Association. It was made clear to hospital representatives present that the word "independent", as used by the C.N.A., does not imply something completely apart from the hospital with which it is associated. The joint committee attempted to draft an exact definition and this will be submitted to the member organizations for their information and comment. At a subsequent meeting, comments received will be reviewed by the joint committee.

We believe that much good can come from this type of meeting. The coming together of medical, nursing and hospital representatives at a joint session can serve many useful purposes. Very often differences develop between organizations because they do not fully understand the point of view or language used by another group. While these meetings have much value at the national level, they can produce equally good or better results at provincial levels. We would

suggest to our member associations that, where they do not have standing committees of liaison with the medical and nursing groups in their provinces, the establishment of such committees would be of mutual benefit.

Does Your Hospital Believe in Accreditation?

PROGRESS of the Canadian Commission on Hospital Accreditation during 1957 was reviewed at a recent meeting. Present were representatives from the four organizations comprising the Commission—The Canadian Medical Association, L'Association des Medicins de langue française du Canada, the Royal College of Physicians and Surgeons of Canada, and the Canadian Hospital Association.

Reports were submitted by Dr. Karl E. Hollis, the former director, and by Dr. W. I. Taylor, his successor. Of the 153 hospitals surveyed in Canada, 107 were surveyed by the Canadian Medical Association and 46 by the American Hospital Association. Comparative figures for previous years were: 1956, 120; 1955, 139; 1954, 155; and 1953, 90. Of the 153 hospitals, 17 were initial surveys. By size, the total number of hospitals surveyed included: 25-50 beds, 22; 51-100 beds, 23; 101-150 beds, 35; 151-200 beds, 26; over 200 beds, 47. Of the 153 hospitals, 133 were accredited, 15 were not accredited, and five hospitals were visited but not rated.

Apparently hospital accreditation has not as yet gained the momentum in Canada that it has in the United States. This passivity is particularly noticeable in hospitals of the 25-100 bed size. Hospital accreditation cannot be pressed on any hospital from the outside, as we all know. It is a voluntary educational movement; no hospital is visited unless it has requested a survey. A desire to meet the standards must come from within the hospital itself.

Since the accreditation movement is one which sets standards for good patient care, it requires the wholehearted, co-operative effort of the board, the medical staff, and the administration to meet these standards. With good patient care its primary purpose, the Joint Commission is concerned particularly with the medical staff organization, medical practice in the hospital, the quality of medical records and those departments which contribute directly to the quality of this care. The only way to ascertain how your institution compares with others in these respects is to have a survey. If your hospital has been surveyed and not accredited, the reasons will have been given by the Joint Commission. It is a matter then of striving to meet whatever deficiencies the survey revealed.

The program of accreditation under the Joint Commission has now been in operation for several years. It is a direct outgrowth of the former Hospital Standardization Program of the American College of Surgeons, which was carried on for some three decades. Where a hospital of over 25 beds has never requested a survey, therefore, there is an implication that the hospital is not concerned with good patient care. This should be a matter of reflection by the board, since they, in the final analysis, are responsible to the community.

Most people in the hospital field believe that accreditation is a worthy objective for any hospital. We believe that, since the work of the Joint Commission on Hospital Accreditation has been going forward since 1952, by now hospital medical staffs, boards of trustees and administration are relatively familiar with the standards of the Joint Commission. One wonders why there is still inertia. Dr. J. B. Neilson, Treasurer of the Canadian Commission on Hospital Accreditation, addressing the 33rd Convention of the Ontario Hospital Association said:

"The advancement of the accreditation program requires much more enthusiasm on the part of hospitals than has been evident in the past. There is no easy road to accreditation since there is no ceiling on good medical care. I think you must agree that the reward is worth the effort and that the hospital displaying the hall-mark of accreditation is one which can properly merit the respect and confidence of the community it serves." (See *The Canadian Hospital*, January, 1958, page 45)

Accreditation is a unique movement which is gaining influence in North America. There is much to be said in favour of this program remaining a voluntary one, sponsored and conducted by medical and hospital organizations themselves. On the other hand, it is reasonable to expect that if hospital and medical organizations cannot rouse interest among their own members — with the increasing use of public money to finance hospitals—at some stage hospital accreditation will cease to be a voluntary educational program and become a function of government. What we would like to see in 1958, particularly in hospitals between 25 and 100 beds, is a much greater appreciation of the importance of hospital accreditation as a means of improving standards of patient care.

Votre Hôpital est-il partisan de l'Accréditation?

LES progrès de la Commission Canadienne d'Accréditation des Hôpitaux au cours de 1957 ont été examinés lors d'une récente assemblée. Y assistaient des délégués des quatre organisations qui composent la Commission—L'Association Médicale Canadienne, L'Association des Médecins de langue française du Canada, Le Collège Royal des Médecins et Chirurgiens du Canada, et L'Association des Hôpitaux du Canada.

Des rapports furent présentés par le Dr. Karl E. Hollis, ancien directeur, et par le Dr. W. I. Taylor, son successeur. Des 153 hôpitaux du Canada dont le cas a été examiné, 107 ont fait l'objet d'une étude de la part de l'Association Médicale Canadienne et 46 de la part de l'Association des Hôpitaux Américains. Les chiffres correspondants pour les années précédentes étaient les suivants: en 1956, 120; en 1955, 139; en 1954, 155; et en 1953, 90. Pour 17 des 153 hôpitaux, il s'agit d'une première étude. Par ordre de grandeur, l'ensemble des hôpitaux dont le cas fut étudié se décompose comme suit: 22 de 25 à 50 lits; 23 de 51 à 100 lits; 35 de 101 à 150 lits; 26 de 151 à 200 lits; 47 de plus de 200 lits. De ces 153 hôpitaux, 133 ont été accrédités, 15 ne l'ont pas été, et cinq hôpitaux ont été inspectés mais non classés.

Il est évident que l'accréditation des hôpitaux n'a pas encore acquis au Canada l'élan dont elle bénéficie aux Etats Unis. Cette passivité se remarque en particulier dans les hôpitaux de 25 à 100 lits. On ne peut amener un hôpital à se faire accréditer par des pressions de l'extérieur, comme nous le savons tous. Il s'agit d'un mouvement éducatif volontaire; aucun hôpital n'est inspecté s'il n'a pas demandé que son cas soit examiné. Le désir de satisfaire à de meilleurs standards doit émaner de l'hôpital lui-même.

Du fait que le mouvement d'accréditation fixe des standards correspondant à des soins de qualité, il faut, pour parvenir à ces standards, que le conseil d'administration, le corps médical, et les services administratifs collaborent activement et de tout coeur

(Suite page 98)

a symposium

REHABILITATION MEDICINE

SOME five years ago I was privileged to forecast this coming trend. It seemed to me then that, for the next decade or so, emphasis in hospital care would shift somewhat from the field of disease to the field of disability. I felt then that the emphasis in the next ten years would move toward rehabilitation medicine, the scope of which is essentially the prevention and treatment of mental and physical disabilities.

An adequate rehabilitation program requires the participation of psychologists, social workers, speech therapists and educationalists. Rehabilitation implies the treatment of the whole patient, as a mental, physical, social, moral and emotional entity. Unless the rehabilitation team has a thorough and complete knowledge of how the patient will think, feel, and act under all sets of circumstances, the team cannot be fully effective in helping the patient.

If one takes a fleeting, bird's-eye glimpse of the treatment picture over the past 50 years, one will recall that during this century the concept of the therapy of the mentally diseased has changed from one of custodial incarceration to kindly, sympathetic, effective treatment. The past decade in particular has seen the emphasis shift very materially to the prevention and treatment of mental disabilities in all age groups. In the field of physical diseases, the first half of this century saw the conquest of most of the communicable diseases, particularly smallpox, diphtheria, typhoid fever, scarlet fever, the meningidities, pneumonias, venereal diseases, tuberculosis (to a lesser degree), and, recently poliomyelitis.

The 1920's brought us insulin for the treatment of diabetes, and liver extract for the treatment of anaemias. The 1930's, with the introduction of the chemo-therapeutic agents, such as sulpha drugs, saw the beginning of the conquest of those bacterial organisms which our late professor of medicine, Dr. Egerton Pope, referred to as "the vile harbingers of death", namely the staphylococcal and streptococcal infections. The 1940 decade may be described as the antibiotic era in the history of medicine. The chemotherapeutic agents and antibiotics took a great deal of the futility out of therapy.

It is obvious that, with the conquest of disease, with isolation hospitals as such no longer required, with tuberculosis hospitals being closed in many parts of Canada, we now have the opportunity of directing our hospital and medical facilities towards the disabling diseases and injuries, both mental and physical. With industry and traffic increasing at a tremendous pace, with the disabilities of two world wars in the past 50 years requiring every rehabilitative device available, and with such conditions as cerebral palsy and arthritis everywhere in our midst, the need for rehabilitation medicine is, or should be, obvious to all.

—A. C. McGugan, M.D.

These remarks are from Dr. McGugan's introduction when he acted as moderator of a panel discussion on "Rehabilitation Medicine, The Hospital Trend of Today and Tomorrow", presented at the annual convention of the Associated Hospitals of Alberta in Edmonton, October, 1957. The following papers are from the same series.

Psychological Aspects

K. A. Yonge, M.D.*

A MODERN trend is the focus of more attention on the psychological influences upon physical process. The idea of "psychosomatic" medicine has a modern ring about it, for doctors today are claiming that from ten to ninety per cent of their practice concerns illness in which the psychological factors are more influential than the physical ones.

Far from being a modern idea, the bearing of psychological influences upon physical health is a very old one. In the ancient world, in the earliest of all known institutions of healing—the temples of Aesculapius—the doctor was at the same time the priest. Medical care involved various lotions and potions as physical measures, various activities which today we might call occupational therapy and physiotherapy, as well as religious ministrations to the needs of the soul. Thus, at the beginning of medical history, medical care was comprehensive or multi-directional.

The trouble in those days was that the practice of medicine and the practice of religion were both mixed up with magic. This did not continue long before certain sensible and down-to-earth physicians, seeing the tangibility of the physical processes, wanted to divorce physical medicine from nonsensical magic. Unfortunately, in trying to do this, physicians by and large concentrated their attention so much on the physical processes that they fell into the error of overlooking the psychological or spiritual influences upon these processes. Quite properly wanting to get rid of the magic and superstition associated with health, they threw the baby out with the bath water. Even as far back as 400 B.C., Plato saw this and complained that the physicians of Athens, in trying to treat the ailments of the body, were neglecting the soul. He pointed out that you could not properly cure the part unless you paid attention to the whole. "The cure of a part should not be attempted without the treatment of the whole, and also no attempt should be made to cure the body without the soul, and therefore if the head and the body are to be well, you must begin by curing the mind: that is the first thing. Let no one persuade you to cure the head until he has given you his soul to be cured. For this is the great error of our day in the treatment of the human body: that physicians separate the soul from the body."

In spite of Plato's wisdom, there grew up in people's thinking about health, an artificial separation or segregation between the physical process on one hand and psychological phenomena on the other. People came to think of most illnesses as purely physical, requiring purely physical treatment and having little to do with the pyschological state of the patient. Psychological considerations were for the mentally ill, and that was an entirely different matter, people thought.

The progress of medical research over the years has now shown that health and disease cannot be considered as purely physical. There is an inseparable interaction between the physical process and the psychological experiences in all illnesses. What the patient thinks and feels has some effect, sometimes a profound and crucial effect, on his physical well being. This has become particularly apparent with those patients whose chronic disability has kept them under the doctor's observation for long periods of time. These are the patients—victims of polio, cerebral palsy, and the aged with their disabilities—who are particularly thought of in programs of rehabilitation. They are often patients with marked and more or less permanent physical disabilities. The task of rehabilitation is to help these patients develop new skills, new strengths—new life, if you like. This is a problem much larger and more complex than, say, the mechanical stimulation of muscular action. All useful muscular activity is controlled by the brain—the body's Grand Central Station. Grand Central is the terminus not simply of trains but, also, of a vast, milling crowd of people who use the trains. Similarly, the brain is the terminus not simply of mechanical nerve impulses to all parts of the body, but also a vast, milling crowd of fears, hopes, inclinations and intentions. Certainly, the people at Grand Central Station depend on the movement of the trains, but the movement of the trains is ultimately determined by the desires and needs of the people. Similarly, this milling crowd of fears, hopes, inclinations and intentions which is one side of every person may largely determine the activity of any part of the body. So much of the success or failure of the physical methods of training a body to renewed activity depends on how the patient feels and thinks about himself and about life in general.

Here is a recent example. Mr. A. had been in hospital on and off for the best part of a year. His trouble was indigestion. It was known that he had had ulcer trouble, on and off, for many years. During the last year he had had two operations for stomach ulcers and, in his own estimation, he was worse now than he was before. There was a feeling among the hospital staff that he had become unduly dependent on hospital care and perhaps there wasn't really much wrong with him after all. But, as far as he was concerned, his stomach was not working properly. He was losing weight and felt thoroughly miserable. The medical staff had found there was no evidence of any ulcer or other structural damage in his stomach to account for the symptoms. He now seemed hypochondrical, fretful and complaining, but he had not been this way for most of his life.

An eager and hard working man, he had worked steadily, and enjoyably, in a machine shop up to the age of 70; but, for many years, he had had the kind of indigestion that goes with stomach ulcers. His was the kind of temperament, too, that goes with stomach ulcers. But, in spite of it, he had rarely lost a day of work on account of sickness.

Having been retired from work at the age of 70, his wife dead for many years, no children, he was leading a dismal and empty life in a rooming house. Naturally, he felt useless and unwanted. His self-confidence had gone. Having nothing in particular to live for

(continued on page 100)

*Dr. Yonge, as well as being a professor of psychiatry at the University of Alberta, is also the director of the Department of Psychiatry, University of Alberta Hospital.

Environmental . . .

M. T. F. Carpendale, M.D.*

A FEW months ago a "polio" patient was referred to our department because she wished the polio foundation to buy some expensive equipment for her, and she wanted a medical certificate to the effect that the equipment was necessary. She could not move from her bed to her wheel chair, nor could she move from her wheel chair onto the toilet.

Although she had paralysis of both legs and trunk muscles, her arms were quite strong. She thought that if a "monkey bar" were built over the bed, she could possibly move herself from the bed to the wheel chair, and that if she had a hydraulic lifter it would be easier for somebody else to lift her from her wheel chair onto the toilet.

When she came for evaluation it was found that physically she had been well rehabilitated. Every muscle that could work was working to its maximum ability. Mentally she was also well rehabilitated. She was not only well adjusted to her disability, but well motivated and determined to live to the hilt of her capacity.

It was felt that she should have a period of training in the two things that she especially wanted to accomplish independently—namely, to move from bed to wheel chair, and wheel chair to toilet. Accordingly, we determined the height of her bed at home, and had a sketch plan of her bathroom to figure out how near she could bring her wheel chair to the toilet. We then found a bed of the same height as her own, and we "mocked up" a rough approximation of her own bathroom and toilet.

For five months this determined young woman had been doing her best to try to conquer these two obstacles to her independence and self respect. With the help, suggestions, and instructions of a therapist well versed in rehabilitation technique, she mastered them both in two weeks. Independently she could now move in and out of bed and on and off the toilet. Not only could she do it in the hospital setting but also in practice at home. This accomplished everything that she required without marring her house or furniture, and without costing the foundation about $300 for what would have been completely unnecessary equipment.

This case illustrates the great gap that exists between the circumstances of the dependent patient in hospital and the independent individual at home. It also illustrates the value of training disabled dependent hospital patients to become independent at home. This process we have called "environmental rehabilitation".

You may think this is a rare type of case, but it is not so. Every day patients with varying disabilities who have been hospitalized come in for some phase of environmental rehabilitation.

Arthritic patients, some of them hospitalized for two or three months, have had drugs and conventional physiotherapy, heat and massage, and exercise. But nobody has asked them if they can comb their hair, put on their stockings, or lift a saucepan off the stove, and these are the things the patient must do if he wishes to maintain his independence at home.

Then too there are patients who walk into hospital, but go home in a wheel chair—amputees. They buy an artificial leg, try it out for a while, then give it up in disgust and return to their wheel chair. Buying a limb does not enable you to walk. Stump conditioning and training, in the case of an artificial limb, takes time in expert hands; it does not come naturally.

There are many who come who have suffered from strokes. They may have paralysis of one arm and leg. The man is dependent because he can't tie his tie or shoelace with one hand. The woman is dependent because she can't open a tin, butter bread, or cut meat with one hand. Nobody has asked her if she could do these things or offered to show her how to do them independently.

Then there are the patients with paralysis of both legs who are confined to wheel chairs. The most expensive chair is ordered regardless of the patient's requirements. (The most expensive chairs are usually the biggest.) It is too big for the patient's home, so it is relegated to the garage, and the patient has to be lifted and carried.

What is the remedy for this sad state of affairs? All patients with residual disability, after their medical and surgical treatment, require evaluation to determine how independent they will be when they return to their home environment. This evaluation is normally made by putting a patient through a series of tests which include the activities of normal daily living. These activities have been well analyzed by Dr. Howard Rusk and his group at the Institute of Rehabilitation in New York, in the "Activities of Daily Living" Chart. After putting the patient through all these tests, a clear idea of the areas in which he is most dependent can be obtained. This may be in dressing, feeding, toilet, walking, or wheel chair activities.

Having determined the areas in which the patient is dependent, a

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training program is begun to enable the patient to accomplish the task unaided. If it cannot be done unaided then various gadgets, *e.g.* the "monkey bar" in bed, or adaptions of existing apparatus may be used. Only as a last resort is help from another person allowed because this spells *dependency*. When the patient can accomplish all of these activities of daily living in the hospital environment he is sent home and finds out the things he cannot accomplish there.

A further bout of training, possibly some of it in the home environment, is then undertaken. Finally, if the patient is still dependent, modifications of the home itself may be required to make the patient independent.

Who can bridge the gap between dependency in hospital and independence at home? A well-trained physiotherapist can. Even in a small department with one therapist, such as one might hope to find in any 50-bed hospital, much can be done. Nearly all the evaluation and training which will enable the patient to leave the hospital confident that he will be independent at home can be done by that therapist.

Whose responsibility is it to see that the patient bridges the gap between dependence in the hospital and independence at home? The physician in charge of the patient clearly owes this to his patient. However, he cannot be expected to do this himself; he has a right to the services of personnel and a department that can provide them for him. It is the hospital's responsibility to provide such facilities and personnel.

Firstly, it is important to the patient because it enables him to obtain a state of independence more quickly and efficiently. Secondly, it is important to the doctor because he can provide the patient with services which are essential for the best final results from his treatment. Thirdly, it is important to the hospital because it cuts down the hospital stay of long-term patients and improves patient relationship with the hospital.

Environmental rehabilitation is the process of converting a dependent hospitalized patient into an independent individual at home. Mary Switzer has said it is "a bridge that spans the gap between uselessness and usefulness, between hopelessness and hopefulness, between despair and happiness". It is our duty to build that bridge.

Setting Up a Section

M. C. Adamson, M.D.*

EVERY hospital, no matter how small or how few its facilities, should provide rehabilitation services. At least 20 per cent of the cases in a general hospital should receive some benefit from physical medicine in order to ensure a shorter period of convalescence and a better restoration of function to injured joints, muscles, tendons and nerves. This means rehabilitation. Rehabilitative measures should include care of short time cases as well as chronic; care in strains, sprains, and fractures; and care in skin conditions from burns to psoriasis. Care in organic disease, in circulatory disease from peripheral vascular to cardiac, as well as pre- and post-operative care from knee to chest surgery, should come under consideration too, along with ante and post-partum care.

The large arthritic group from the osteoarthritis of the older patient to the rheumatoid arthritis of the younger patient, which needs care in both acute and chronic stages, should be included in the rehabilitation program.

Rehabilitative care of the spastic child, and those cases needing long care, such as the quadriplegic (polio, et cetera), and multiple sclerosis, is needed, plus care of psychiatric cases. Even allowing for care in those cases where specialized treatment is necessary, and those long standing cases which would rapidly overload the department, and those cases where governmental responsibility is acknowledged, it is easily seen that 20 per cent is a minimum figure.

Outlined here are the minimum requirements of a rehabilitation section. The first division to be set up should be physiotherapy.

A 50-bed hospital, keeping in mind the 20 per cent figure, should expect to treat 10 cases, at least, in its rehabilitation program. One physiotherapist can manage just about that many cases in a day if the treatment is on the ward. Much more efficient is a small department where the therapist can treat three patients at a time—one under a lamp or short wave diathermy, one under massage or joint mobilization, and one under supervised exercise. With such a department the number of patients may be raised to 15 or 18 daily, even if some cases need increased supervision and individual care.

After making an estimate of the probable number of treatments, choose the right personnel. A properly trained director must be in control, and treatment must be prescribed with a definite end in view. Success of the department depends on satisfying both patients and the referring physicians. In small hospitals a roentgenologist who has had some training in physical therapy might serve as director. Otherwise, it is essential that some member of the medical staff acquire sufficient knowledge to supervise the department. Larger hospitals can afford to employ a part-time director, and the big hospitals will benefit from the services of a full-time director. His job is to direct or administer treatment and examine patients at frequent intervals to make certain they are gaining ground.

An important member of the rehabilitation team is the occupational therapist. Her duties are re-training the patients in the activities of daily living. With a view to small hospital needs some of our Canadian training centres are turning out technicians who are both physical and occupational therapists.

Location of department

The best location is on the ground floor, in a well-ventilated and well-lighted room, because fresh air is vital in a place where exercises are to be given. In a 50-bed hospital a room 30 feet by 24 feet would be satisfactory. It would provide space for four treatment cubicles (six feet by eight feet), an exercise

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section and desk. In a 250-bed hospital a space 40 feet by 60 feet is recommended.

Equipment

Ninety per cent of physical therapy in general hospitals consists of common sense and intelligent handwork. Elaborate apparatus and machine therapy alone do not make a section of physical medicine. Minimum requirements would include two home-made bakers ($22.00), one paraffin bath, and one tank for underwater exercises. Exercise apparatus, such as shoulder wheel, exercise steps, shoulder abduction ladder, overhead slings and pulleys, stall bars, parallel bars, and posture mirror, may be made by the hospital carpenter.

When circumstances warrant, and only then, one might add one short wave diathermy unit, one low frequency machine for galvanic and faradic currents, one whirlpool bath, and one ultra violet generator (carbon arc).

It Is Your Problem

J. R. Fowler, M.D.*

REHABILITATION has become an exceedingly popular phrase since World War II. It has been used in the economic sense as rehabilitation aid for farmers. It has been used to refer to ailing automobiles—"Let us rehabilitate your car with a complete overhaul". Even the loan companies now talk about "rehabilitating one's financial ills". If we analyze the word, however, we see that it comes from the Latin, meaning "to live again,"—and what could be more descriptive when we begin to tackle the problem of the severely disabled.

From the medical standpoint, rehabilitation entered into its present prominence by reclaiming the casualties of World War I, through the civilian institute for the crippled and disabled in New York, now world famous, and through the industrial program for injured workmen begun in the early thirties in Ontario. Today the rehabilitation problem gives us an even greater challenge, because it touches every strata of society and embraces all age groups.

In discussing this problem it is most important to remember that *rehabilitation is everybody's business.* In the hospitals of every community there is an increasing number of long-term patients. The trend in solving the shortage of acute active treatment beds has been to shift these people into older sections of the hospitals, including basements, or to transfer them to nursing homes, or mental hospitals, or even to open new institutions for the chronically ill. Unfortunately, all that is being provided in these cases is superficial nursing and custodial care. It is indeed a poor answer to an ever increasing problem which burdens the taxpayer, meaning loss of potential wage earners, and making staff shortages a perpetual worry in all branches of medicine.

This present situation is due to several things, but the most obvious is the marked elevation in the standard of living in the western world which has resulted in larger families, fewer personal responsibilities, and a tendency to "let the government take charge". Along with this trend, medicine has advanced so rapidly and efficiently through preventive measures and therapeutic drugs that the life span has extended from an average of 45 in the early 1900's to the point where three score and ten is quite commonplace. On account of these advances, however, we are now seeing a far greater number of diseases requiring special care which in the past would have succumbed to intercurrent infections. People suffering from heart diseases, rheumatic fever, arthritis, cerebral palsy, multiple sclerosis, diabetes, poliomyelitis, cord injuries — such as paraplegics, now fill our hospitals. As a result of our aging population, the degenerative diseases have led to the specialty of geriatrics and all its problems of self-care in the hemiplegic, osteoarthritic, dementias and many others. In order to treat these numerous and varied disease entities, modern medicine has felt obliged to move into hospitals, causing a scarcity of active treatment beds for the short-term patient. This trend has been perpetuated by the public's demand for hospital care and neglect of the rôle it could play in encouraging the disabled to maintain activitiy in society or in the home for a longer period of time.

Medical philosophy until now has been primarily devoted to preventative medicine and the utilization of the vaccines, pasteurization, sterilization and hygiene education, along with therapeutic medicine and its modern advances in drugs, antibiotics, and improved surgical techniques. The medical student has been indoctrinated in the teaching of prevention of disease and preserving life. It is now time that we appreciate a third phase of medicine; and our philosophy must be extended so that it includes the responsibility of seeing that every patient with a residual disability is exploited to the utmost. The medical doctor must accept responsibility of leadership in salvaging a patient's residual functional potential through direction and use of physical, psychological, social and vocational services in order that the patient may attain some degree of personal independence in self-care and be given an opportunity of obtaining economic independence. This will require a team of especially trained people who, under the leadership of the physician, will work toward these common goals.

Let us now return to the third phase of medicine and its relationship to the medical profession, hospitals, employers, the community and the patient. Rehabilitation, whether we recognize it as such or not, is and has always been practiced as a part of medicine. The general practitioner has been the strongest proponent because he knows the family, is a ready, sympathetic listener, and has supported or bolstered the chronically ill through encouragement and physical aid as far as his time and knowledge would allow. In this fast moving world of today there seems less time for each problem, nor is one man capable of ministering or advising on the over-all problem of the rehabilitation of the severely disabled. It has been recognized that a rehabilitation team should consist of a doctor with leadership qualities who is interested in rehabilitation, and a medical team of

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consultants, physiotherapists, occupational therapists, speech therapists, psychologist, prosthetist, and a social welfare officer. These are the basic personnel, but the non-medical side should include vocational instructors, both educational and technical, and job counsellors or rehabilitation officers.

The doctor's responsibility is to examine and establish a firm diagnosis, and to recommend the appropriate medical, surgical or physical treatment required. He also must evaluate the disability and prognosis before and after instituting treatment. The question is where do we obtain such people. In Canada there are no more than 25 especially trained. The over-all program of rehabilitation could be supervised by other doctors if they were interested and had the time. The interest could be stimulated by introducing the third phase of medicine into the medical curriculum on the same level as preventive and therapeutic courses.

Properly trained physiotherapists still do not meet the demand —it is still necessary to depend on migrant overseas therapists to fill out the various departments. Fortunately, the Alberta Government gave support to the establishment of a physiotherapy school in 1954, and since then there have been two graduating classes of approximately 15 in each class—small numbers to fill the vacancies of all western Canada, but a start.

The nursing profession could contribute in the early stage of rehabilitation, especially when there are no physiotherapists available, by practicing and educating the patient in the simple procedures of self-care and bed independence. Through their early association, much could be done in fostering good morale and hope for independence in the patient.

Occupational therapists are in extremely short supply in this country, in active treatment hospitals, as well as in mental institutions, and tuberculosis sanatoria. There are at present only three schools in Canada training such people, and the numbers graduating fall far short of the demands. Their skills encourage the patient in mastering self-care. By strengthening weak muscles through occupational activities they foster, in the early stages of recovery, the patient's confidence, his sense of achievement, and work habits by therapeutic occupations. They are able, finally, to evaluate the patient's work capacity.

Speech therapists are in exceedingly short supply, yet the demand for their services is constantly increasing in the retraining of people with speech defects through disease—especially the hemiplegic and the palsied child.

Psychologists have aided considerably in assessing a patient's aptitude, interests and motivation —all extremely important in the over-all planning of the patient's future. In 1954 a survey revealed that 95 psychologists were needed annually, but only between 60 and 70 are graduating. At the University of Alberta about two graduate each year.

In large centres a limb fitter or brace maker should be available full-time to provide immediate adjustments on all appliances.

A social worker has been found to be an indispensable member of the rehabilitation team. Through such a person the patient's social, environmental, family and economic problems can be alleviated to a greater degree, and thus pave the way for practical transition from the hospital to the home. Many cases have been successfully completed physically, only to find that on transfer to the home —through lack of education, indoctrination, et cetera—the patient is unable to manage. The result is acute depression, heart break and subsequent return to the hospital. Although there are a good number of social workers graduating each year in neighbourhood universities, they have been absorbed into all kinds of vocations other than this responsible position on a rehabilitation team. In Canada at present there are approximately 250 graduating; a survey has revealed 800 vacancies.

Vocationally, the team should have the benefit and co-operation of outside agencies who would be prepared to carry on schooling by correspondence, technical training on a graduated time basis to include shoe repairing, welding, watch-making, and draughtsmanship. Unfortunately, at the present time government vocational training institutions make no allowances for the severely disabled so that a wheel chair rehabilitee or a polio case with weak muscles cannot enter the building or handle ordinary machinery which might be made adaptable to the disability by minor adjustments.

Finally, there is a need for rehabilitation officers, or National Employment Service special placement personnel who are alert to to the job potential in the community and can advise on the demand for especially trained people.

A word must be said now about the small community hospital and its relationship to such a team. Naturally, every community could not support such an organization; nor would it be practical. However, every community hospital has, or will have, severely disabled people in its beds in increasing numbers. These people are going to vary from the elderly with their associated diseases to younger patients crippled by disease or accident. If they are not suitable candidates for referral to a centre and all-out rehabilitation, they at least can be taught self-care, and many can be made to ambulate. Secondly, the families could be educated to accept responsibility for these cases. Thirdly, the local business people, by thoughtful co-operative planning, could arrange for some position in the economic life of the community where these people could still command an income which would maintain their self-respect, and at the same time lighten the taxpayers' load.

In conclusion, I would like to say that rehabilitation does pay. This has been proved by a survey set up by the United States Department of Labour in a controlled study of 500 disabled civilians with an annual average income of $148.00. This group was given the benefit of rehabilitation services, and after two years the average annual income was $1,768. Whether we in Canada are in accord or not, we must realize that unless something is done to reduce the rising numbers of institutionalized disabled people we are going to find that hospital costs will soar, the taxpayers' burdens will grow heavier, and there will be an ever increasing shortage of professional medical and hospital personnel.

I am convinced that with dynamic thinking, a rehabilitation program handled by the staff in the small hospital or in a rehabilitation centre with all services in communities over 100,000 will forestall this snowballing of hospital costs and bed shortages. By regenerating the self-respect of the disabled person, increasing the national income, and by levelling welfare costs in maintaining these people, a good rehabilitation program can contribute to a better, happier community.

at the University of Alberta Hospital

A MEDICAL REHABILITATION CENTRE

M.T.F. Carpendale,
M.R.C.S. (Lon.), L.R.C.P. (Eng.),
Director, Rehabilitation Centre.

and

H. Arthur Henderson,
B. Arch.,
Supervising architect.

THE rehabilitation of a disabled person consists of three main phases—medical, psycho-social and vocational. In theory, in a comprehensive rehabilitation centre, all three phases should be equally represented. However, it is unusual to find this to be so in practice. These centres tend to be either medically or vocationally orientated. It seems to be difficult to strike a happy balance and from the patient's point of view it may be that two separate centres are the best solution. For a patient whose primary problem is a disability which can be markedly improved with medical treatment then a centre with a medically orientated rehabilitation program is desirable. But for the patient whose disability is static and which cannot be improved by medical treatment, then clearly, a vocationally orientated centre would be a necessity.

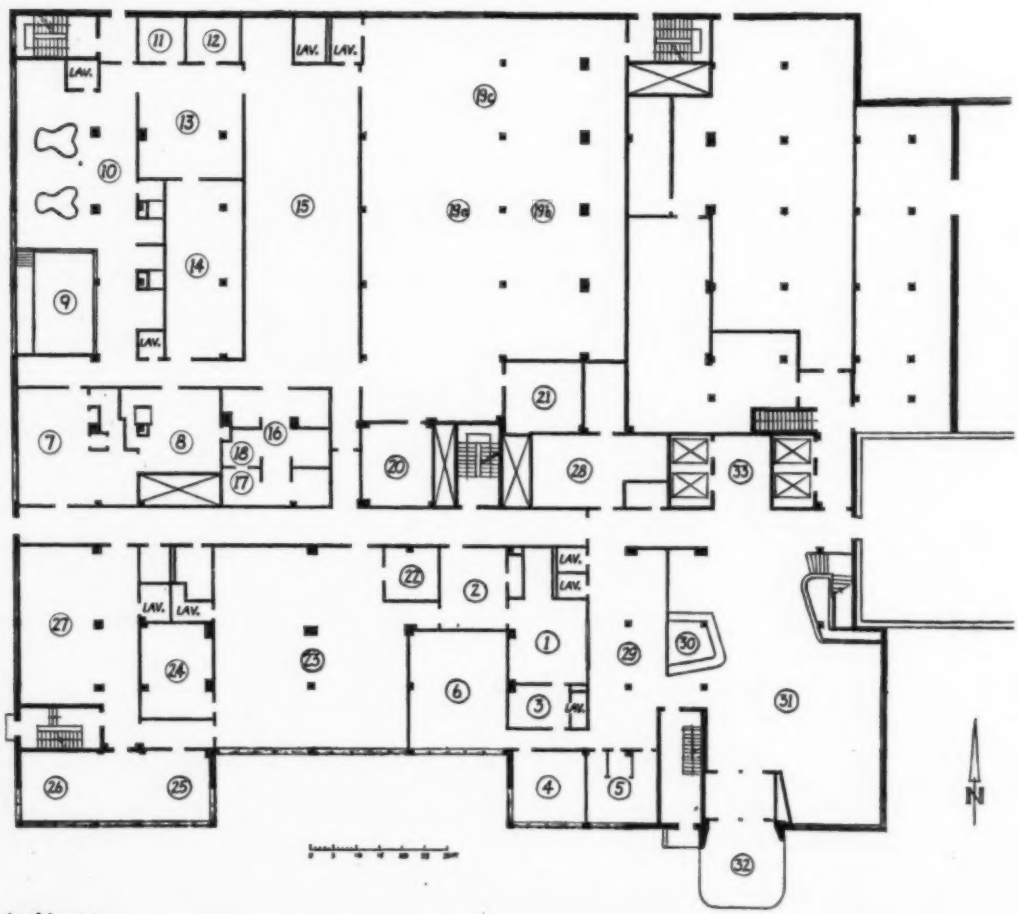
Rehabilitation has only come into its own as a major field in the past decade. This is due mainly to the increased life expectancy and decreased mortality from acute diseases—making chronic illness the major health problem of today. Because rehabilitation is a new field, insufficient time has elapsed since the completion of new centres to judge whether their buildings fulfil the function for which they were conceived. There is no doubt that the majority of newly constructed independent rehabilitation centres are medically orientated. Vocational training for the disabled is left, too often, to what local facilities are available—for the fit individual. Although many disabled persons can go through normal training schools a significant proportion of the severely disabled require special types of vocational training, special facilities and instructors who understand the problems of people with disabilities.

In general, the value of the medical phase of rehabilitation is accepted, but the extreme importance of having a special centre for vocational training of disabled people is not sufficiently appreciated. In planning rehabilitation facilities for a community where no pattern of rehabilitation has been established (as was the case at one time in Edmonton) the best use has to be made of existing facilities.

A large general hospital, with a good physical medicine department and good out-patient facilities, can serve very adequately in the phases of medical and psycho-social rehabilitation.

Key

1. Main office
2. Doctor's consulting room
3. Doctor's consulting room
4. Doctor's consulting room
5. Out-patient clinic
6. Plaster room
7. Steam bath room—male
8. Steam bath room—female
9. Pool
10. Hydrotherapy
11. Linen room and sluice
12. Storage room
13. Wax and hot pack room
14. Rest room
15. Physiotherapy cubicles
16. U.V. light cubicles
17. Screened room for Electromyography
18. Electromyography recording room
19. Gymnasium—
    (a) area for class exercise
    (b) heavy resistance room
    (c) area for gait training
20. Storage room—gymnasium
21. Staff dressing room
22. Storage room—occupational therapy
23. Occupational therapy
24. Activities-of-daily-living
25. Occupational therapy office
26. Training kitchen
27. Recreation room
28. Patients' snack bar
29. Rehabilitation waiting room
30. Information desk
31. Lobby
32. Main entrance
33. Elevators



Architects:
Department of Public Works, Province of Alberta
Consultant, W. L. Somerville, Toronto, Ontario

If this is already available then an independent rehabilitation centre can be constructed which is orientated primarily towards vocational training for the disabled with only minimum medical facilities.

If such a plan is followed, it obviates the re-duplication of facilities in one phase (*i.e.* medical rehabilitation available in both hospital and rehabilitation centre) and inadequate coverage in another phase (*i.e.* inadequate facilities for vocational rehabilitation).

The importance of developing two major types of centre, one medically orientated, usually part of or in close association with a hospital, and one vocationally orientated has been stressed by Gorthy*. This author, the director of The Institute of Crippled and Disabled in New York, clearly points out the special requirements of each type of centre. The article to which I refer, written as it is by the director of probably the best vocationally orientated rehabilitation centre on the continent, and a man of great experience in the field of rehabilitation, merits the closest study by hospital or other authorities interested in the development of rehabilitation facilities in their community.

The present article is concerned with describing a rehabilitation centre with a medical orientation. It is housed in the rehabilitation department of a large university hospital and all types of medical rehabilitation are undertaken, but there are no facilities for vocational rehabilitation.

It is hoped that in the near future a large independent rehabilitation centre will be constructed with a strong orientation towards vocational rehabilitation — to complement the present centre and with it to provide comprehensive rehabilitation for all the disabled in this community.

The severe epidemic of poliomyelitis in the summer of 1953 in Alberta showed up the lack of adequate facilities for the treatment of poliomyelitis — especially when of epidemic proportions. As a result of this in January 1954, an order-in-council was passed by the Government of Alberta authorizing the construction of an addition to the University of Alberta Hospital. This building was to provide accommodation for the care and treatment of acute and chronic poliomyelitis cases throughout the province. Later, with the declining incidence of poliomyelitis and the successful use of Salk vaccine, it was decided that the rehabilitation department should not only treat polyiomyelitis, but be available for the treatment of all other types of disability amenable to physical rehabilitation.

1. Plaster room

To meet this need W. L. Somerville of Toronto was retained as consulting architect and plans were prepared by the Department of Public Works under the Hon. A. J. Hooke, Minister, and Arthur Arnold, Deputy Minister.

In planning the new rehabilitation department prime consideration was given to its location. The existing department was located in the basement of the D.V.A. pavilion and was accessible from the hospital only by a long walk-through tunnel. As a large percentage of patients using this department would be out-patients, it was imperative that it should be located as closely as possible to the main entrance of the hospital which was to be shifted to the new addition.

To avoid congestion of vertical traffic it was thus determined that this department should be on the main or first floor level. The first floor level was approximately one foot above grade, thus with gentle ramps and cut-away curbs, out-patients in wheel chairs could gain access to the department with ease. To further facilitate this access for wheel chairs, crutches and canes, mat-operated power doors are being installed at the entrance.

Waiting Area, Main Office and Consulting Rooms: The main waiting area (29)* for rehabilitation patients is directly off the main lobby (31) and is accessible to both the public information counter (30) and the administrative office (1) of the rehabilitation department. Special toilet facilities have been provided here for waiting patients. From this waiting area, patients can be directed to the offices of the medical staff (2, 3 and 4), out-patient clinic (5), plaster room (6) for the replacement of casts, et cetera, or directly to the various sections of therapy.

Plaster Room: (Photo 1) The plaster room (6) has deliberately been kept remote from other areas for various reasons. Many of the patients coming to this area need not re-enter the main therapy department, and this avoids a considerable amount of traffic through a busy area. Again, the untidyness caused by working with plaster is confined to a small area and thus a general appearance of neatness is maintained throughout the department.

Three curtained cubicles are provided in this room for plaster application. Above the cubicles, suspended from the ceiling, is a 4" x 4" steel mesh. From this, counterbalances can be suspended to aid in the manoeuvring and positioning of limbs during the application of a cast.

At the present time the plaster

**Willis C. Gorthy, 1957: "The Shortage of Vocationally Orientated Rehabilitation Centres". Journal Rehabilitation, Vol. XXIII No. 4., July-August, 1957, p. 9.*

**All numbers in brackets refer to numbers on floor plan of rehabilitation department.*

2. Hydrotherapy

room combines the functions of plaster room and room for ultra-violet light therapy. As neither light therapy nor the application of casts are very time-consuming procedures this appears to be a useful economy of space and provides three more treatment cubicles (14) and one extra storage space.

Out-Patient Clinic: There is a small out-patient clinic (5) near the doctor's office, planned for combined clinics between the rehabilitation and other departments, *e.g.* orthopaedics, rheumatology, neurology, et cetera. This clinic has been especially designed to allow for a quick turnover of out-patients. Each of the two dressing cubicles has a door opening onto the waiting room and also a curtained opening separating it from the examining room. In this way, one patient can come in and change while another is being examined—each having complete privacy. Following examination the patient can dress and leave without passing through the examining room while the other patient is being examined. The third door provides entrance and exit for medical personnel or stretcher cases without disturbing the privacy of the dressing cubicles.

Physical Medicine

The physical medicine section lies north of the main corridor which runs east and west through the department. This section is made up of separate areas which provide space for steam baths, hydrotherapy, wax baths and hot packs, rest room, physiotherapy, ultra-violet light therapy, electromyography and a gymnasium.

Steam Bath Room—Male (7): This room contains two steam baths, three plinths for massage or heat from electric bakers, one shower to cool patients after the steam bath, and one arm and leg whirlpool bath.

Steam Bath Room—Female (8): This room is similarly equipped but has no whirlpool baths.

These steam baths differ from conventional types in that there is a sprinkler shower in the cover of the cabinet which enables the patient to cool before assuming a vertical position. This is extremely valuable in treating young patients and patients with hyper-tension—both are types which may suffer from syncope if they quickly assume an upright position after their body temperature has been raised.

Hydrotherapy: (Photo 2) This section (10) is in a large, brightly tiled room and contains a stainless steel pool (22′ x 12′), two Hubbard tanks, a one-arm and one-leg whirlpool, and changing and showering facilities for both men and women.

The pool and the two Hubbard tanks are serviced by a common overhead electric hoist, for ease in handling patients.

In the pool (9) stainless steel was used in preference to tile in the cause of cleanliness. It is, however, more slippery than was anticipated. The pool itself is five and a half feet deep at its deepest point and has steps to a depth of two feet. Each step is three feet wide and extends across the 12-foot wide pool, providing a good walking area at each depth. The deepest portion of the pool is used for very weak patients so that they can get maximum support from the complete immersion of their body. As their power improves they move into the shallower areas where more effort has to be exerted to walk with less of their body weight supported by the buoyancy of the water.

The floor at one side of the tank was lowered in order to assist therapists in the manipulation of patients, but is seldom used and the consensus is that for adequate control in pool therapy the therapist must be in the pool with the patient.

One of the Hubbard tanks has a counter sunk base to a depth of about three feet and this can also be used as a walking tank. It has adjustable parallel bars inside it, and has been found especially useful for patients who have insufficient confidence to walk in the open pool.

The second Hubbard tank is kept scrupulously clean to enable it to be used for sterile hydrotherapy, such as exercising burned patients under water.

In addition to normal shower facilities, there are special areas where stretcher patients can be changed and dried.

Wax Bath and Hot Pack Room (13): This room contains four cubicles, a sink, a hand and foot wax bath and one hydrocollator unit for hot packs. In addition to the treatment with wax baths and hot packs, this room is also used for abdominal and vaginal diathermy. The sink is used for washing applicators and wax.

Off this room there is a combined linen and hopper room (11) where all the physiotherapy department linen is kept, and also where urinals and bed pans may be emptied.

Next is a storage room (12) where all small equipment and apparatus from the physiotherapy

3. Physiotherapy section

4. A physiotherapy cubicle

section is kept. Large equipment, *e.g.* heat lamps and diathermy machines, is kept in two cubicles, one in the middle of the physiotherapy (15) and one in the area originally planned for ultra-violet light therapy (16).

Physiotherapy (15): This division (Photo 3) contains twelve cubicles separated by movable round-the-bed curtaining. Above seven of the cubicles there is a 4″ x 4″ square iron mesh work which enables any type of suspension therapy (one limb or whole body) to be carried out with ease.

Each cubicle (Photo 4 and 5)

5. Suspension therapy in action

6. Class exercises and remedial games area

is equipped with one plinth, a chair and a shelf (large enough for a time clock, call bell, massage powder, oil, spirit, and hand towels) and below the shelf are two double hooks 18 inches apart, and one towel holder in the middle. This arrangement allows each patient to hang up all his individual items of clothing and leave the chair free. Also in each cubicle there is a wall mirror 16″ x 24″, mounted 44″ from the ground. This size of mirror, placed at this height from the floor, enables patients in wheel chairs to see their head and shoulders and patients sitting on the plinth for exercises to see their whole trunk which is very important in sitting, balance and breathing exercises.

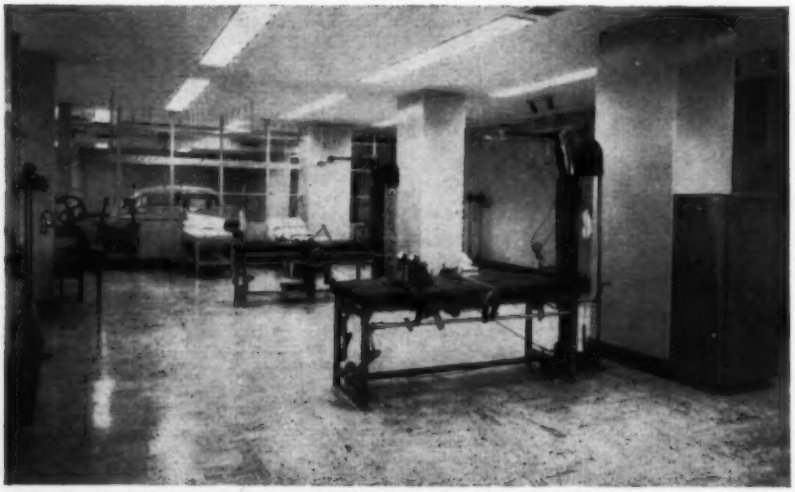
Rest Room (14): This area contains six couches and is surrounded by hydrotherapy, wax bath room, steam bath rooms, and physiotherapy. It is designed as a place for patients to rest after thermotherapy, hydrotherapy or exercise therapy, and also an area where patients may rest while waiting to be taken back to their wards.

On the north side of the physiotherapy section is a recess with flat-topped tables where therapists can write up notes, and lockers for filing.

Also opening off the north end of this area are two toilets, for males and females, each of which is large enough to allow for easy maneuvering of a wheel chair. They are equipped with grab rails and an overhead rope ladder suspended from a hook in the ceiling. With these facilities the majority of paralysed patients can take care of their own toilet needs. However, in case the patient gets into difficulties there is a hanging cord close at hand which activates a buzzer outside the toilet, and the doors are equipped with locks which can be opened from the outside, if necessary.

At the south end of this area, opposite the entrance from the main corridor is a desk for the chief therapist. On the walls are charts indicating the therapists' time tables, whereabouts of patients, patients to be collected from the wards, et cetera. All this traffic the chief therapist can regulate from his desk.

Ultra-Violet Light Therapy (16): At the south end of the physiotherapy section are three cubicles separated from each other by wooden partitions. This provides greater privacy than round-the-bed curtaining and these cubicles are therefore normaliy kept for ultra-violet



7. Heavy resistance room

8. Gait training area

light therapy or examining rooms. Recently it has become apparent that the plaster room can house ultra-violet therapy as well, so these cubicles are mainly used as examining rooms.

Electromyography Screened Room (17): Two adjoining cubicles are used for electromyographic examinations, one for a screened room and one for a recording room. The screened room is used for electromyographic examination. The recording electrodes and leads to and from the preamplifier are kept in this room, while the oscilloscope, stimulators, et cetera, are kept in the next room (18) which is not screened. The room is double screened with bronze wire approximately the same mesh as normal mosquito screen wire. A screened door separates it from the recording room.

Recording Room (18): This room contains a double beam oscilloscope, a stimulator, audio oscillator, tape recorder and microfilm reader. There is a transparent screen between this and the screened room so that the oscilloscope in the recording room can be seen from within the screened room.

Gymnasium (19): The general plan has been to provide ample space (88′ x 56′) for the various functions of this room. A special feature of proven value is a 30″ x 30″ steel grid embedded in all walls, for the anchoring of wall mounted equipment.

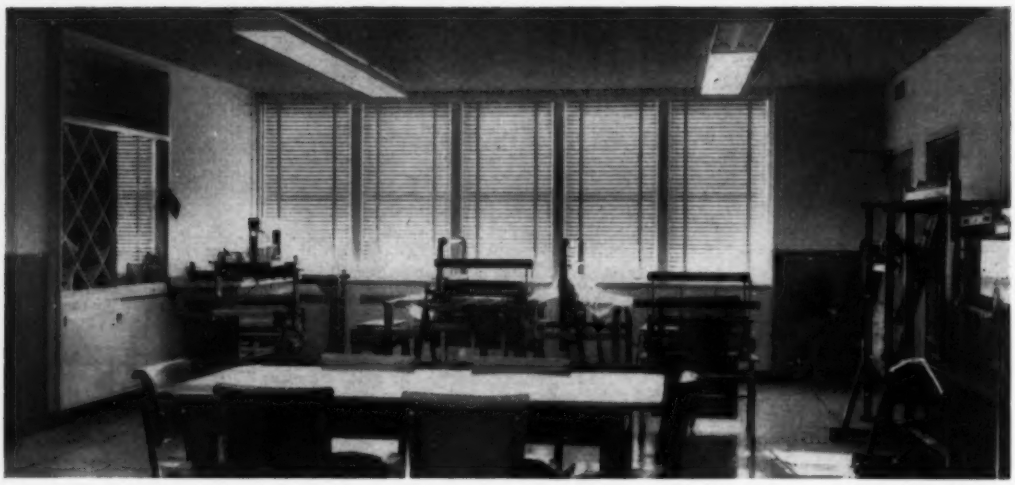
The gymnasium is divided into three main areas:

Area for class exercises (19a): (Photo 6) This space (30′ x 62′) has screened-over head lights and has no equipment, except wall fixtures such as shoulder wheel and ladders, so that it is used for general exercise classes, mat exercises and organised indoor competitive games, including indoor ball games such as wheel chair basket ball.

Heavy Resistance Room (19b): (Photo 7) This room (27′ x 48′) contains five wall pulleys, two overhead pulleys and two exercise tables, all for graded resistance exercises. It also contains a plinth for horizontal lumbar traction and a bench for Delorme quadriceps exercises.

Area for Gait Training (19c): (Photo 8) This area (26′ x 56′) contains two sets of fixed parallel bars, adjustable for height, and one set of portable parallel bars adjustable for height and width. There is one oblong overhead track to support patients with gait disturbances in overhead harness. Also there is a series of ad-

9. Potter's wheel, kiln, sink and sewing machine



10. Weaving is encouraged in this section

justable steps for training in climbing stairs. A car, without the engine, is mounted in this section to train wheel chair patients to get in and out of the car without help. A low bed, with an overhead frame, is available for training wheel chair patients to get in and out of bed. A small treadmill is kept in this section for exercise tolerance, and general work test measurements. There are also four tilting tables for postural therapy.

At the south end of the gymnasium is a storage room (20) for equipment. This has space for braces, crutches, canes, basket balls, et cetera.

Also opening off the south end of the gymnasium is a dressing room (21) for the staff which has locker space for twenty.

Occupational Therapy

The occupational therapy section is on the south side of the building and because of the extensive use of glass is usually flooded with brilliant sunshine. In this area, (Photos 9 and 10) where the keynote appears to be space for manoeuverability, patients work at various forms of handicrafts such as needlework, leather work, weaving, pottery, painting, basketry and a small amount of carpentry. All the looms, potters' wheels, lathes, jig saws, et cetera, are powered by the patient to develop various forms of remedial correction. Ample storage is a necessity here to provide space for the patients' projects and for extra supplies.

Activities of Daily Living Room: (Photo 11) The "Activities-of-Daily-Living Room" (24) has been equipped with domestic furniture. The patients are trained here in all types of self-care activities, such as how to dress themselves, feed themselves and perform their toilet. Here also, wheel chair patients are taught how to get in and out of a domestic bed, on and off a toilet and various types of domestic chair, and in general how to use standard bits of domestic furniture and bathroom facilities.

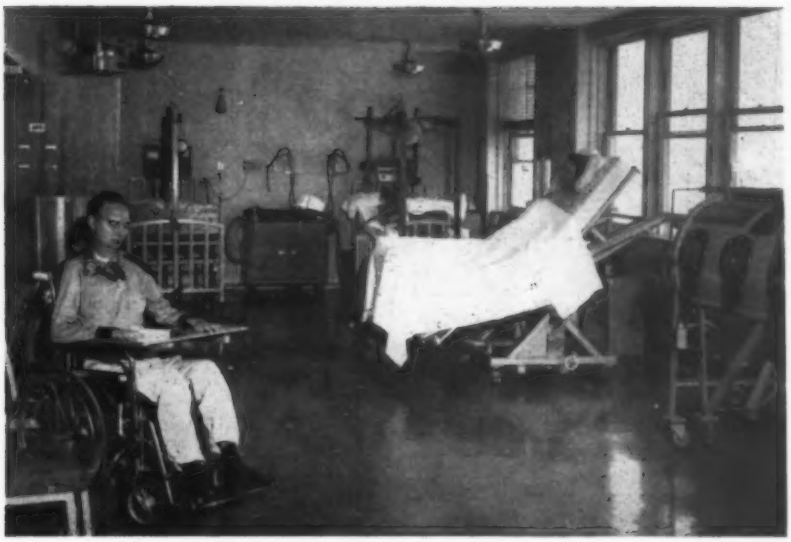
Training Kitchen: (Photo 12) The training kitchen (26) is to be used to instruct patients in handling the kitchen equipment found in the average home. The hot plate and oven are separate units. Each can be moved to any part of the kitchen to simulate the patient's home environment as closely as possible. In this way a more realistic work test is possible.

Also the height of the oven and the hot plate can be adjusted to resemble all standard types available and enables each patient to decide what is the most suitable height of working surface for herself.

This idea is a modification of that designed by Doctor Svend Clemmensen, director of the Danish Foundation of Poliomyelitis in Denmark, and has proved to be very satisfactory.

Recreation Room: The recreational therapy room (27) is primarily a games area. Ping pong, shuffleboard, checkers and dancing facilities are provided. It can also serve as a lecture room.

Following treatment in the vari-



13. Respirator ward

ous departments, all patients can easily return to the administrative office, to arrange future appointments, for example, and then may proceed directly to the public waiting area, or to the passenger elevators and their respective wards throughout the hospital. The location of the department has proved to be most satisfactory, and unrelated through-traffic to other hospital departments has been eliminated. Again, it is stressed that brightness and ample space is one of the keynotes for the successful and convenient operation of this department.

Poliomyelitis Unit

The sixth floor, which is designed in two nursing units, is equipped for the care and treatment of poliomyelitis patients. The west wing is an isolation unit for acute or infectious poliomyelitis. The main respirator wards are located here (Photo 13). They are designed to accommodate eight respirators in each ward, as well as rocking beds, and other bulky equipment needed. These rooms are air-conditioned by individual packaged units and each ward has its own humidity control. The wall by each bed has piped in oxygen and suction available.

The east ward on this floor is similarly equipped for respirators but will be used as a rehabilitation ward. However, should the need ever arise, the hospital now has provision for conversion for care of sixty-eight acute respiratory poliomyelitis cases.

A spacious roof deck has been constructed, with direct elevator service. This has proved to be a most useful area. The roof deck is sheltered from the north by a masonry wall and a portion of it is protected by a canopy to provide shelter from inclement weather.

The construction of the building is of steel frame and reinforced concrete slab on steel open-web joists. Interior partitions are of hollow tile and building block. Exterior walls are hollow tile and brick to match the existing structure. Construction was started in the spring of 1954 as plans were being developed and the building was finally completed in the summer of 1957.

11. Activities-of-daily-living room

12. Training kitchen

A STUDY

The Hemiplegic in Hospital

Dr. J. R. D. Bayne
and
Dr. Marjory W. Warren*

THE onset of a "stroke" is a devastating occurrence by which an active, independent person may be reduced to a bedridden cripple. It is generally recognized that much improvement can be achieved by rehabilitation, but for maximum success the treatment should begin as early as possible, before the patient becomes demoralized by full appreciation of his deficits and before contractures develop in the affected joints and muscles.

In some instances it may be possible to treat the patient at home, but the majority will probably require treatment in hospital. In such a common condition, the assessment of the case and early initiation of therapy should be carried out at the local general hospital. Therefore the hospital admitting such a case must be prepared to offer treatment and should know that by so doing a large proportion of patients surviving the initial disaster will achieve personal independence. Whether they then go home or elsewhere depends on their social circumstances, but they will cease to be a hospital responsibility.

To illustrate this we are presenting the results of treatment of all hemiplegic patients admitted to this general hospital in one year (1949). Cases excluded from analysis were those that had only a history of transient unilateral weakness clearing before admission, or terminal hemiplegia in patients suffering from other conditions. Also excluded were cases of hemiplegia which had already been treated in this hospital previously and were being readmitted for various other reasons.

The majority of cases were admitted directly to the geriatric unit where physiotherapy, occupational therapy and the ward routine were co-ordinated to encourage maximum early independence. Some cases were treated on the general medical wards initially and if they did not make good progress were transferred to the geriatric unit. The retraining method was that described previously by one of us.[1] Attached to the unit was a long-stay annex for the care of cases who were not benefitting from treatment in the unit. These cases were nevertheless kept under supervision.

Material:

Of the 131 admissions considered, two were readmissions in the same year for recurrent hemiplegia. There were 57 men (43.6%) and 74 women (56.4%). The ages ranged from 31 years to 92 years, with a peak distribution in the eighth decade (see Table I). In two cases the age was not recorded.

Sex Differences:

From Table I it can be seen that there were more women than men in all age groupings, but that the proportion was the same in the decades from age 60-90. Table II shows that of the 53 patients who died within 6 weeks after admission, 22 (41.5%) were men and 31 were women, which is the same proportion as the total admissions. There was, however, a slightly higher proportion of men discharged within 6 weeks after admission (50%) than of the total proportion of men in the group. In the group remaining in hospital over 6 weeks the proportion of men discharged (33%) dropped while the proportion of women discharged (66%) rose. The proportion of male deaths rose to 60.9%. In other words, men tended as a group either to achieve independence early or not at all.

Onset:

Tables IIIa and IIIb relate the time elapsing between the onset of the hemiplegia and admission to hospital with the outcome either of death or discharge. Among the 55 patients (41.9% of total) admitted within 48 hours of onset the death rate was high (see Table IIIa). In the first 48 hours after admission 7 patients died, and another 15 died in the next 2-14 days, making a total of 22 deaths (40% mortality). A total of 86 patients were admitted within two weeks from the onset of the hemiplegia of whom 49 (56.9%) died in hospital. Of the patients who survived 34 (39.5%) were discharged and three patients were transferred elsewhere —one to a home for incurable cases, and two to mental hospitals (see Table IIIb).

It should be noted that only one patient was finally classified as a "long-stay" case, if by that is meant there was no further progress with treatment. If, however, merely remaining in hospital for over three months is considered "long-stay" then, of the 86 patients admitted within two weeks from the onset of the hemiplegia 17 or 19.7% were "long-stay" cases. But of these 17 cases, 14 or 72.3% were finally discharged. It can be seen, therefore, that it is of the utmost importance to continue rehabilitation for a prolonged period, and to reassess patients frequently.

There were 45 patients admitted to hospital over two weeks after the hemiplegia had occured, and in 11 cases it was more than a year after. Since such patients are usually very difficult to treat, they may remain on the wards for long periods of time. In neglected cases the first task is to overcome the apathy and despair resulting from a demoralizing helplessness. Of the 45 patients, 27 (60%) died eight of them over three months after admis-

From a study done by the authors in West Middlesex Hospital, Isleworth, Middlesex, England. Dr. Bayne is now at the Sherbrooke Hospital, Quebec.

1. Care of the Hemiplegic Patient, by Dr. Marjory Warren. The Medical Press, May, 1948. Vol. CCXIX, No. 5687.

sion, and one was transferred to the long-stay annex. However, 17 (37.7%) patients were discharged, and eight of these required over 3 months of rehabilitation. Both in the first group admitted within two weeks after the onset of hemiplegia, and in this group admitted after a delay, it is those patients who require over three months of intensive treatment to achieve independence who test the ability and keenness of the hospital team. Of the whole group of 131 admissions, 62 (47.3%) died within three months after admission and another 14 (10.6%) died later; 51 patients (38.9%) were discharged.

Previous cerebro-vascular lesions:

A number of cases gave a history of previous episodes of cerebro-vascular disturbances before the one causing admission. Of the total of 40 patients who gave a history of one or more previous attacks, 14 (35%) were discharged — slightly less than the total percentage discharged (38.9%).

Other Conditions:

In the whole group, auricular fibrillation was present in 17 and irregular cardiac rhythm in two others. In the group eight patients were men. In 12 of these cases the hemiplegia affected the right side of the body and in seven it affected the left side; 12 patients died.

Investigations:

The Wassermann Test (W.R.) was done on the blood in 51 cases and was positive in three. This test was done on the cerebro-spinal fluid in 38 cases and was positive once. Of three cases with positive blood W.R. the cerebro-spinal fluid was W.R. positive in one, negative in one and not tested in one.

Outcome:

Since the majority of hemiplegic patients were elderly, the aim of the rehabilitation program was to grant them independence in their personal needs rather than to make them entirely self-supporting. On discharge they would be able to wash and feed themselves, dress themselves and walk with perhaps some slight help in maintaining balance, and they would have been doing these things daily for some weeks under supervision. A patient was not considered ready for discharge if he required actual support in walking.

Table I

Age and Sex Distribution of Vascular Hemiplegias Admitted in 1949

Age	Under 60 Years	60-69	70-79	80-89	Over 90	Unknown	Total
Male	5	19	19	12	—	2	57
Female	8	23	26	16	1	—	74
Total	13	42	45	28	1	2	131

Table II

Time Spent in Hospital by Women and Men Until Their Discharge or Death

Time in Hospital		Within 6 Weeks After Admission		Over 6 Weeks After Admission	
		Number	Percentage	Number	Percentage
Discharged	Men	9[1]	50	11	33.3
	Women	9	50	22[2]	66.6
	Total	18	100	33	100
Died	Men	22	41.5	14	60.9
	Women	31	58.5	9	39.1
	Total	53	100	23	100

[1] Plus 1 to a mental hospital.
[2] Plus 3 transfers: 1 to a mental hospital, 2 to long-stay accommodation.

Table IIIa

Duration of Hemiplegia Before Admission Related to Time in Hospital

Onset Before Admission	Died Within 48 hrs.	Died Within 2 Weeks	Died Within 3 Months	Died Later	Total
0-48 hrs.*	7	15	9	—	31
49 hrs.-14 days	1	8	6	3	18
15-42 days	—	3	5	3	11
42 days +	—	2	6	8	16
Total	8	28	26	14	76

*Including 2 cases with onset while in hospital for other disease—one C.C.F., one Rh. Arthritis.

Table IIIb

Duration of Hemiplegia Before Admission Related to Time in Hospital

Onset Before Admission	Discharged in 1 Month	Discharged in 3 Months	Discharged in 6 Months	Discharged over 6 Months	Transfers	Total
0-48 hrs.*	5	7	6	4	1 Home for Incurables 1 Mental Hospital	24
49 hrs.-14 days	3	5	3	1	1 Mental Hospital	13
15-42 days	1	3	2	1	1 Long Stay Annex	8
42 days +	3	2	4	1	—	10
Total	12	17	15	7	4	55

*Including 2 cases with onset while in hospital for other disease: one C.C.F., and one Rh.Arthritis.

Table IV

Proportion of Men and Women Discharged to Own or Welfare Home, or Who Died

	No. of Patients	%	Discharged Home	%	Discharged to Welfare Home	%	Died	%
Men	57	100	19	33.3	1	1.8	36	63.1
Women	74	100	24	32.4	7	9.4	40	54
Total	131		43*		8		76*	

*4 patients were transferred, in addition to these listed as discharged or died.

Table V

Follow-up of Discharged Patients Showing Survival Time and Independence

Time After Discharge	Up to 2 Weeks	2 Weeks to 3 Months	3-6 Months	6-12 Months	1-2 Years	2-5 Years	Over 5 Years
Died	—	4	3*	7	6*	7	—
Surviving Still Independent	42	38	35	28	22	15	15
	37	33	32	25	22	13	11

*Includes one patient last heard of at this time.

Of the 51 patients discharged from the group, only two were not in this category. One of these patients left hospital against medical advice soon after admission, and the other, a woman aged 31, required considerable help in walking, but could manage well in a self-propelling wheel chair.

Table IV shows the outcome of treatment for men and for women. It can be seen that while approximately the same percentage of men and women were discharged home, a higher percentage of men died and a higher percentage of women were discharged to old people's homes (welfare homes). This may be due to the following factors. We have seen already that men tend either to improve quickly or to die earlier than women. When the patient improves quickly the family is usually expecting him to return home, but slow improvement may break down this expectation and lead the family to request transfer to a welfare home instead.

Since women as a group in the general population outlive men and widows greatly outnumber widowers, a hemiplegic woman is likely to be a widow. When ready for discharge she may be faced with living alone with a residual disability. Whereas a hemiplegic man would have a surviving spouse to return to, a widow may have to go into a welfare home.

Follow-Up:

A follow-up study was made of those 51 patients who were discharged to determine how long they lived and how long they remained independent. The 19 patients living near the hospital were visited, but for the others letters were sent to the general practitioner or to the patient for information. In eight cases the patients had moved and could not be traced or there was no reply to the letter. Two other patients had moved from the region, and although the neighbours could say when they were last seen alive, no further information was elicited and they could not be traced.

Of the 43 patients traced, one was the woman of 31 years, who on discharge was not ambulant but could manage a self-propelled wheel chair. The follow-up of the 42 patients, discharged ambulant, is given in Table V. There can be seen the number of deaths occurring with the passage of time and the number of those surviving, and also the number of the survivors who remained independent. The two patients mentioned before who could be traced only to the time when they moved from the district are listed as if they died then.

In 17 cases a history was obtained of a recurrent cerebrovascular disturbance after discharge. If the patient became ambulant again he was listed as having maintained his independence throughout, because it is believed that a person who can recover his independence after a "stroke" at home without re-entering hospital probably is no more of a burden to his family than if he had had any other temporary upset. Of the 42 discharges seven were people under the age of 60, and 16 were men.

Table V shows that five patients lost their independence within two weeks of being discharged, but it is remarkable how well the survivors in each time period maintained their self-sufficiency. Not only did 15 patients live over five years after discharge, but 11 of them remained independent. Four of these remaining independent were under 60 years of age when admitted to hospital.

There were six people who later required admission to an institution for long-stay nursing care, of whom three are still alive. The young woman, who on discharge required a wheel chair but was otherwise independent, has remained so.

In addition to the patients discharged there were two patients transferred to a mental hospital. One of them, age 52, with presenile dementia, died three years and five months later. The other, age 62 years, died 18 months later from carcinoma of bronchus and pulmonary abscess (autopsy).

Discussion:

The cases of hemiplegia chosen for consideration here were due to vascular disease, but no attempt was made to localize the lesion to a part of the brain or vascular system. All cases suffered from a degree of physical disability, but many also were handicapped by mental impairment.

Cases with minimum disability can be treated at home by the general practitioner, if he is keen to encourage and guide his patient in recovering independence, but more severely affected cases should be treated in hospital by daily physiotherapy. When admission to hospital is decided on this should be done early before complications secondary to the hemiplegia arise. Severely affected persons, especially with mental impairment, require special care. Initially it may be difficult to gain their co-operation and they must be led to attempt easy tasks of immediate practical value, such as washing or feeding themselves. In some cases the mental state never becomes completely normal, but after prolonged retraining a person may be able to manage all the small tasks needed for personal independence. Some cases remain too irrational for

(concluded on page 90)

WANTED: One Medical Record Librarian

Sister M. Catherine,
B.Sc., R.R.L., Victoria, B.C.

WE who work in large hospitals have the same medical record problems as those in smaller institutions, and often in a highly aggravated form. Due to the greater degree of organization possible with a large medical staff, however, we also have more assistance in solving these problems. Some of the solutions we have worked out may be of help to the smaller hospitals.

The Small Hospital and Accreditation

The administrators of small hospitals often ask us, "What are the medical record requirements for accreditation?" A detailed and official answer can be found in the February 1956 issue of *Hospital Management*, where the matter is dealt with fully by Dr. Kenneth Babcock, director of the Joint Commission on Accreditation of Hospitals. The heart of the subject, however, lies in one of his introductory sentences: "Medical records are an important indication of the quality of patient care given in a hospital."

A good history on the patient's chart from the time he enters the hospital is an important tool in the practice of modern medicine. Completed records give the administrator and board of management tangible evidence of the type of medical care rendered in their institution, and assist their efforts to see that this care is of a high standard—their primary responsibility. Hence the real question is not, "What are the medical record requirements for accreditation?" but rather, "What are the requirements for proper patient care?" Just as accreditation is not an end in itself, but is intended as an expert appraisal of hospital activities, neither are records an end in themselves—they serve the dual purpose of assisting in patient care and indicating its quality. They must be a true reflection of what is going on. Records which appear complete but which are inaccurate, are worse than useless; they are like a thermometer that registers normal when the patient has a high fever.

Practical Points in Organization

After these preliminary remarks, let us consider the practical links between patient care and medical records, and what can be done about them in a hospital which is trying to organize a records department.

The first consideration is personnel. The hospital must employ someone to devote herself primarily to medical records, and that person must know what she should do. A registered librarian is desirable, and the administrator may be able to secure one through advertising in the Bulletin of our association, or in other publications. However, if you cannot get a good librarian, it is waste of time and personnel to give a girl a textbook and put her into your record room, hoping that the next time you look in it will be nicely organized. Record room personnel need experience, and in the absence of a trained librarian, the administrator should take a suitable clerk-typist or stenographer and give her a chance to gain such experience in an organized medical record department. She should be told that as the work expands and opportunity provides, a registered librarian may be employed, or she herself may be given the chance to take training, if she proves suitable and so desires. In the meantime, larger hospitals should be willing to help other institutions by including such girls in their in-service educational programs. Unfortunately, certain administrators try to solve the problems by removing a graduate nurse from her ward duties and commandeering her for medical records. I do not refer to those nurses who, for good personal reasons, wish to transfer to another profession, but I speak of cases known to me in which a nurse was recruited for records through urgent persuasion by an administrator who mistook the means for the end, and felt that since accreditation depends upon good records, he was justified in sacrificing some of his nursing staff for this purpose. This, of course, is a fallacy, since any sound record program must *assist in*, not *detract from*, the care of the sick. To remove a nurse from her proper sphere where she is so sorely needed is to contradict the central purpose of all hospital activities. Furthermore, while nursing provides a fine background for a course in medical records, it does *not* give a girl the specific knowledge needed to run even the smallest record department. As I said before, some training under a qualified and experienced librarian is essential to a proper understanding of the place of medical records in the work of the hospital as a whole.

The next consideration is choice of a person. Librarians in fairly large departments have the double responsibility of selecting their own staff and of keeping the administrator informed; hence we acquire some understanding of both points of view. My first advice to an administrator in selecting a person to train for medical records work is this:

1. Secure someone who is honourable and discreet, with no inclination to gossip. This is particularly important in a small community, for she will know all the patient's business, much of the doctors', and just how you run your hospital as well.

2. Do not hire a grumbler. The medical record librarian must be someone prepared to meet the administrator more than halfway—for two reasons. First, because many administrators do not know exactly what may be expected from the medical record department. This has not been my own experience, since I have always had an administrator and superintendent very well versed in medical records; but I am quoting from Dr. Finn, assistant superintendent of

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This paper was presented at the annual meeting of the British Columbia Conference of Catholic Hospitals of Canada, October, 1957. Sister M. Catherine is Medical Record Librarian at St. Joseph's Hospital, Victoria, B.C.

The author would like to acknowledge the kind assistance of Dr. E. N. Boettcher and Rev. Sister Mary Angelus of the same hospital.

Hamilton General Hospitals, whom I heard speak at the convention of the Canadian Association of Medical Record Librarians in September, 1957. He emphasised this point, and asked the librarians present to take the initiative in offering help. The administrators have to rely upon the judgment of the person in charge of medical records in this regard. Secondly, the authorities, according to my experience, are usually reluctant to require too much of the department, and never insist on anything which the librarian even hints will become burdensome for herself or her staff. For these two reasons, an unco-operative person in records can very effectively deny the administrator access to an important source of vital information. You need someone who has the spirit recommended in the gospel when it says, "If any man wishes you to go with him a mile, go with him another two." These are also the happiest people. When they have sincere willingness to lighten the burdens of the administration, then the people in authority and those in medical records really bear one another's burdens. This is to the ultimate advantage of both, particularly to the administrator. Even on the level of economy, a generous spirit pays off, since work studies prove that extra services willingly rendered take less time than the elaborate arguments involved in avoiding them.

3. Besides being co-operative with the administration, the librarian or record clerk must be able to work with other people on the same level, or under her. It is fatal to put a person into medical records because she can't get along with associates elsewhere, thinking you can hide her in the vault and get some good out of her. The Medical Records Department, to function properly, must have good relations with everyone.

4. Your librarian must have the initiative to try to improve her methods, and the courage to persevere in routine tasks even when their value is little understood. The work is quite lonely, because so few outside the department know anything about it; and the remark which reaches her most often is some discouraging opinion that there is no future in paper work. If the administrator hasn't time to encourage the librarian, no one else will, and she must be mature enough to keep on through a sense of duty, and an appreciation of the value of her work to the patients.

What the Administrator Should Expect From the Librarian

The next question is this, "After the administrator has chosen a suitable person and given her a chance to gain experience and to learn technique, what should she be able to do?"

First, she must know how to assist the doctors—and indeed, persuade them to write their histories promptly. They should be written within twenty-four to forty-eight hours of admission, particularly the pre-operative histories. This is a duty which is not sufficiently emphasised. In a new and very admirable textbook which I have read, I was disappointed to find it stated that the librarian's duties begin when the patient leaves the hospital. Since the primary purpose of the record is to help the patient *while in hospital*, it seems only logical that the person responsible for the record room should play some rôle in this aspect of the work.

Secondly, she should encourage and assist the doctors to complete their records after the patients' discharge, and should keep the administration posted regarding the result of her efforts. This should not be merely a matter of asking the doctors once and handing over the whole responsibility to the administrator. She must have some technique of her own, and try to approach the various doctors in the way which brings the best results from each. The psychological element is very important here. There must be no suggestion that the librarian is supervising the doctors' work or telling them what to do. Still less should she appear to assume the administrative duty of correcting them and enforcing discipline. Since she has no authority to do so, her efforts will actually hinder the work of the administrator, as it will give the doctors just cause to complain of the way the hospital rules are enforced. The librarian must show herself entirely loyal to the administration, and at all times desirous of enlisting the loyalty and support of the medical staff for the rules and regulations which they themselves should establish.

Then she must be able to set up an efficient filing system. I do not specify any particular kind, but it is best to have a method whereby all admissions are gathered together in one folder, and can be located properly when required.

Further, she must be able to organize and maintain the necessary indexes, which are usually considered to be these:

(1) An alphabetical index according to the patient's name, with addresses, dates of admission and discharge, serial number of charts, doctor, and preferably diagnoses and operations;

(2) The physicians' index, consisting of a card for each doctor, on which are entered all his patients, and the results of the treatment given them;

(3) The surgical index, which may consist of a simple card of four columns, giving serial number of chart, pre-operative diagnosis, and pathology findings;—the cards set up according to the individual surgeon's name or code number;

(4) Index of diseases and operations. This index is recommended to be kept according to the Standard Nomenclature, but this recommendation obviously presupposes a certain degree of scientific precision in the terms in the diagnoses. Since it must be based on records of a fairly high quality, the librarian cannot always expect to begin with Standard Nomenclature coding, nor indeed, with a disease and operations index at all.

The first step in organizing the records department is obviously the one I named first—urging the doctors to take an interest in producing worthwhile histories. When this has been accomplished, there will be enough interest generated among the medical staff to justify the work of setting up a disease index. It can be started as a simple, alphabetical file, or an abbreviated form of International Coding may be used. The librarian should work the project up gradually, take advice from the doctors and from the administrator, and especially judge for herself how much use will be made of the index. When it is used sufficiently, it is a great asset to the department—hence the librarian should do her best to "sell" the idea to the medical staff, and to stimulate their interest in helping to make it worthwhile.

(5) The librarian must be able to maintain an Analysis of Hospital Services, a book entered day by day, according to patient discharges, designating the type of patient (medical, surgical obstetric, etc.), days' stay, results of treatment, and other important data.

(continued on page 86)

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* National Research Council Report

Dietary Consulting Service

Sine Culver
and
Betty L. King*

THE main function of the Division of Hospital Administration and Standards is to assist the 150 public general hospitals of Saskatchewan in providing a satisfactory standard of hospital care, while, at the same time, maintaining a reasonable economy in hospital operation.

The division consists of a medical director, an assistant director (standards), an assistant director (accounting), two hospital administrative consultants and three auditors, who are employed to assist hospitals with general administration and financial problems. In addition, counselling and consultation services are also provided for nursing service and education, x-ray and laboratory technical services, pharmacy, medical social work, health education, as well as for food service and nutrition.

The division also assists the Hospital Rate Board (an interdepartmental committee) to develop recommendations for rates of payment to hospitals by the Saskatchewan Hospital Services Plan. Technical assistance is provided to the Departmental Advisory Committee by reviews of construction proposals and requests for construction and equipment grants, which are submitted by hospitals.

These various skills are made available to public general hospitals on a team basis, with each team being responsible for a certain geographical area of the province. The hospital administrative consultant, as the team leader, co-ordinates the activities in each area.

Dietary

The services of two dietitians (one attached to each team) are available to public general hospitals for guidance in dietary department construction and alteration, purchasing food and equipment, food cost surveys, food storage and refrigeration, menu planning, food preparation, special diets, food service, sanitation, safety and staff surveys.

Construction

The architect's preliminary dietary department plans are examined for the adequacy of space made available, the general lay-out of fixed and movable equipment in respect to work flow and the relationship of the dietary service area to the hospital in general.

Equipment Purchasing

Every effort is made to guide hospitals toward practical purchases of dietary equipment, commensurate with the anticipated work load, at the particular hospital.

Food Purchasing

It is often found that food purchasing is a problem in smaller hospitals where the cook may be doing the retail purchasing, the matron interviewing salesmen for some of the wholesale purchases, and the part-time secretary-manager purchasing the staple wholesale goods. The principle that purchasing should be the responsibility of *one* person and that there should be a firm purchasing policy is encouraged.

Purchasing should be guided by a suitably planned menu, with orders specifying the amount, quality and brand desired.

We recommend that bulk purchasing be practised when there is available storage space, limiting such purchases to no more than two months' supply. When storage space permits, case goods may be purchased at a discount during the packing season (September or October). Small hospitals are encouraged to buy beef and pork by the carcass, side or quarter. While some institutions have adequate freezing facilities to store these amounts, many rent space in the locker plants. We encourage the purchasing agent to study changing market conditions and, in the beginning, to try new products, brands and grades on an experimental basis only.

Food Costs

Hospitals' food costs as shown in the monthly statistical reports are under continuous review. If they are above the amount approved in the budget, a visit is made to check on the following aspects of dietetic planning:

1. The accuracy of the staff meal count and whether the staff is consuming food between meals. A staff plate count at each meal is advisable unless meal tickets are used.
2. The possibility that cleaning and other supplies are being included in the reported food costs.
3. Are written menus, planned in advance, to cover at least two weeks?
4. Are menus used as a purchasing guide?
5. Is food purchased wholesale, by specification and in containers of a suitable size?
6. Are purchases checked on their arrival at the hospital for quality, size and condition, against a copy of the original order and any found unsuitable returned for credit?
7. Is there effective control of food supplies?
8. Is food properly stored? (Root cellars, refrigeration, et cetera).
9. Are standardized recipes used?
10. Are portions served, tray returns and garbage checked regularly?
11. Is food preserved in the hospital? If so, is it worthwhile from the point of view of labour cost and nutritive value?
12. Is home-made soup stock prepared?
13. Is milk powder used? The use of milk powder in all baking, cream soups, milk puddings and cocoa drinks, which account for about half the milk consumption, can decrease the milk bill by approximately 25 per cent.
14. Is meat roasted at low temperatures, without a cover or water, in order to limit shrinkage?
15. Is there vegetable and fruit peeling wastage?
16. Are leftovers utilized?

If recommendations made after such investigations are followed and food costs still remain high, a food cost survey may be conducted to determine the factors involved.

In Saskatchewan, food cost surveys are conducted to determine the total amount of money spent for raw food by a hospital over a certain period (usually six months). Such surveys provide

(continued on page 106)

**Food Service*

sponsored by the

Canadian Dietetic Association

**The authors are with the Division of Hospital Administration and Standards, Saskatchewan Department of Public Health, Regina, Sask.*

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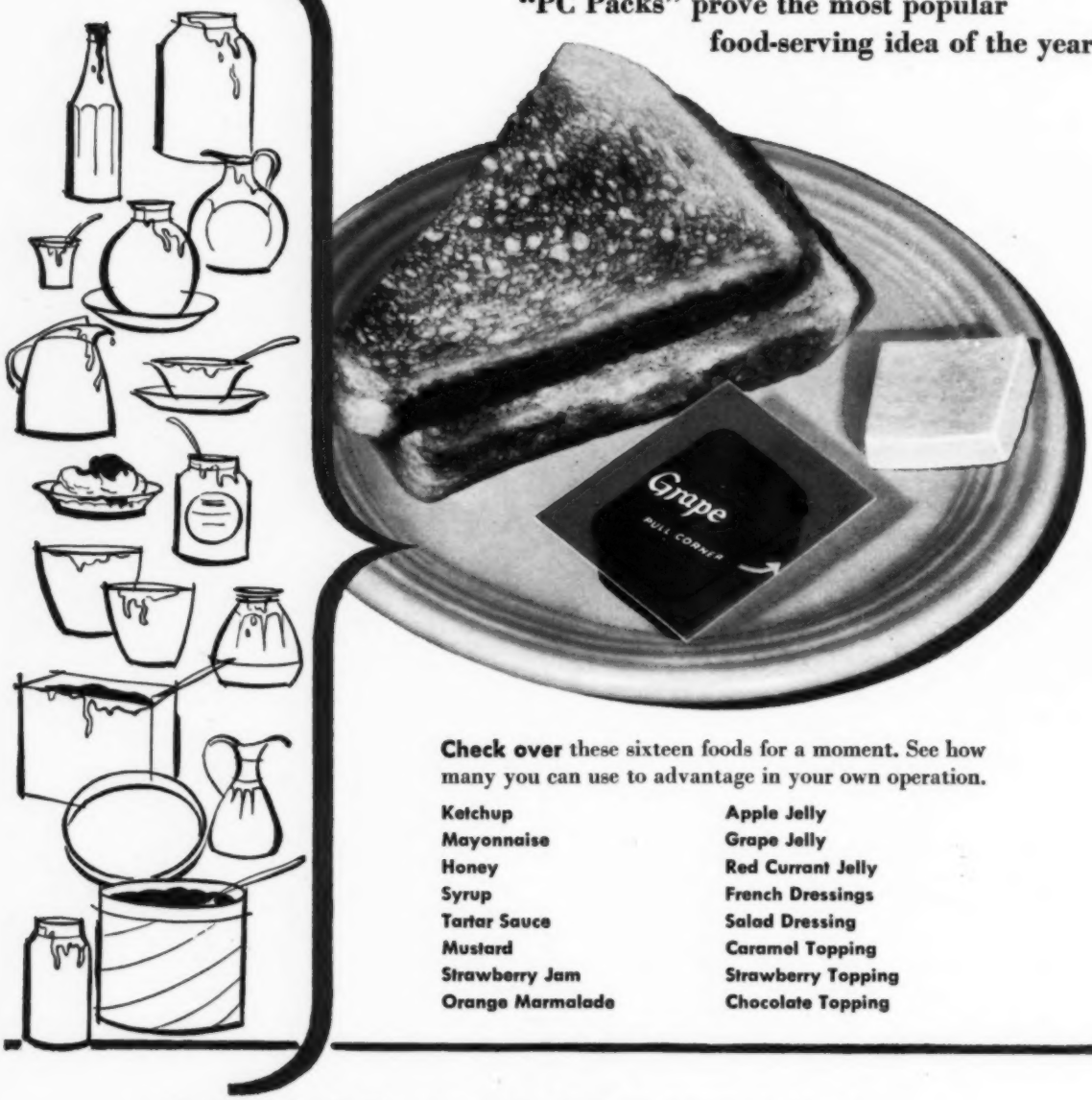

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Syrup	French Dressings
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Mustard	Caramel Topping
Strawberry Jam	Strawberry Topping
Orange Marmalade	Chocolate Topping

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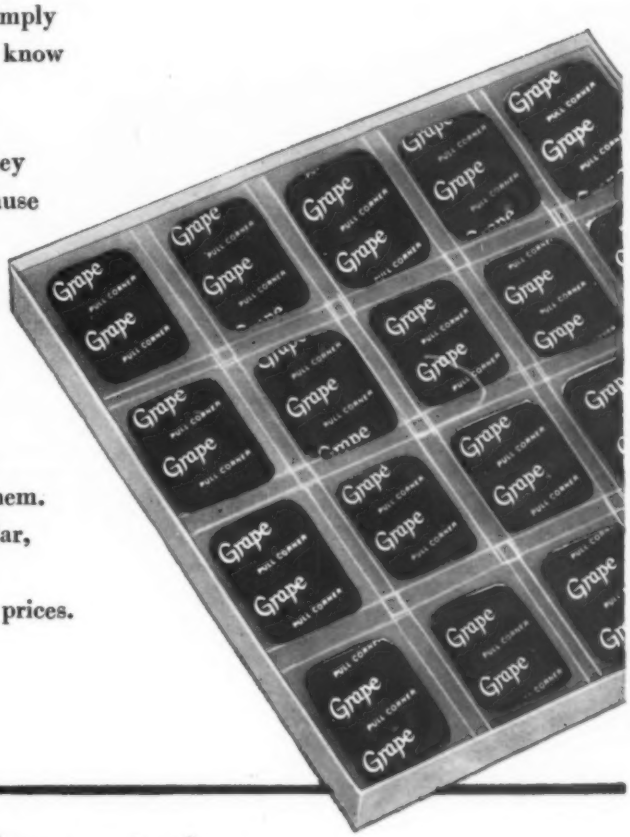
They're well liked—partly because they are clean and pleasant to use, partly because the flavor of Kraft PC Packs is just as delicious as Kraft's regular line of first-quality foods.

They're cheaper—because PC Packs eliminate waste and spoilage, and also *excessive* portions, you'll find your total costs are reduced as soon as you adopt them. Also, because they have become so popular, we now can take advantage of volume production to offer them to you at lower prices. Savings show up immediately.



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Notes on Federal Grants

Increase in Construction Grants

According to news released in Ottawa on January 25th, a new schedule of construction grants has been announced by the Hon. J. Waldo Monteith, Minister of National Health and Welfare. The increased grants will be retroactive to January 1st of this year. The grant for the construction of beds for the acutely ill, which was set at $1,000 in 1948, has been increased to $2,000; those for long-term cases (chronic, tuberculosis, and convalescent) are being increased from $1,500 to $2,000; and the grant for bassinets which stood at $333.33 is now $666.66. The grant for nurses' beds goes from $500 to $750; while that for each 300 square feet of space for emergency cases, diagnostic services, and out-patient department, which was $1,000, is now $2,000.

Two new grants are on the schedule. One provides $750 per bed for intern accommodation; the second being a grant for renovations under certain conditions. This latter grant will only apply on projects which involve *major* alterations and full details have not been made public as we go to press.

Construction

Extensive alterations and additions to the General Hospital at Chilliwack, B.C., will be partially financed by a grant of nearly $142,000. Bed capacity will be increased from 50 to 157 and bassinets will number 27. Accommodation will be provided for maternity, surgical, medical and paediatric nursing. Laboratory, x-ray and physiotherapy will be available for both in and out-patients. There will also be accommodation for 30 nurses. The project is expected to be completed by October of this year.

The nurses' residence of the Highland View Hospital at Amherst, N.S., will be assisted by a grant of more than $9,000. Accommodation for 16 beds, as well as classrooms, will be incorporated into the structure.

A new wing for chronic patients being built by the Montreal Protestant Homes, Montreal, Que., is to be assisted by a grant of more than $222,000. The new building, a five-storey brick and steel construction, will hold 146 beds, physiotherapy and occupational therapy departments, as well as doctors' and dentists' offices. A laboratory will also be included. Completion of the construction is scheduled for May 1958.

Diagnostic Services

The development of a laboratory and of radiological services at Jean Talon Hospital in Montreal North, Que., is to receive federal aid of more than $130,000. Servicing a population of approximately 300,000 people, the new x-ray and laboratory service will be available to all doctors and patients within the area. It is hoped that this service will bring relief to the present pressure on the hospital's active treatment beds. Many patients requiring diagnostic attention, who now occupy 30% of the active treatment beds, could be treated on an out-patient basis.

The Notre-Dame Hospital, Montreal, Que., has been granted $40,500 to establish a clinic of audiometry and orthophony. This clinic will be the first of its kind in French Canada, and will be under the direction of Dr. Fernand Montreuil, who will be assisted by a paediatrician, a psychologist, and a psychiatrist, as well as audiometry specialists.

Public Health

The new operational health unit for Norfolk County, Ont., will receive a federal grant of $26,075. Serving an area with a population of over 45,000, the unit provides a full-time, generalized public health service, and is developing a series of well-baby clinics in various centres in the county, an active immunization campaign against contagious diseases, and improved inspection services to ensure the safety of food and water supplies.

Research

Federal grants totalling more than $71,600 will assist in the establishment of a heart research and treatment centre to be operated jointly by the Royal Victoria Hospital and the Montreal Children's Hospital, Montreal, Que.

Hysteria Not Exclusively Feminine

Hysteria is not exclusively a female disorder, say two psychiatrists who recently reported to the American Psychiatric Association on the subject.

They maintain men have it, too.

They find that psychiatrists who were first to investigate hysteria intensively listed "egotism, vanity dramatization, exaggeration, lying, irrational emotional outbursts, emotional capriciousness, emotional shallowness, lack of emotional control, and both coquetry and frigidity" as the badges of hysteria.

To these, they would add "the demanding, dependent quality of these patients," and they also recommended that two distinct types be recognized, the "conversion hysteria" where there are such symptoms as paralysis of a limb, convulsions, and the like, and "anxiety hysteria", first described by Freud.

Women have no monopoly on either, they revealed, and men are found who fit the description of both types of hysteria. An unconscious reaction toward "the frustrating and hostility-provoking behaviour of certain patients" causes hysteria to be described as exclusively feminine.

They attributed this to "the hostility engendered in doctors by certain patients with non-organic disorders, who are almost invariably called hysterical no matter how transparently conscious the deceptive behaviour may be", and add that, "the production of frustration and hostility in the observer is not a reliable criterion on which to base a diagnosis.

Another reason cited by them for the bad reputation of the female sex for hysterics is the fact that early descriptions of hysteria "were being made entirely by male psychiatrists who may have provoked responses which might not have been obtained by a woman examiner."—*W.N.S.*

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With the Auxiliaries

Gift of a Gadget Box

Thanks to the "Monday Maggies", poliomyelitis patients at the Nora-Frances Henderson Hospital in Hamilton, Ont., can practice the simple, everyday movements under guidance on a portable kitchen. The group belongs to the women's auxiliary of the Hamilton General Hospitals.

This apparatus is a ten-foot long wooden box to which is attached an alarm clock, can opener, light switches, door handles, buzzers and every type of lock, key and tap used in the city. The 50 gadgets include pieces like old-style telephones which are outmoded in large communities but still found in some rural areas.

Tests are given to all patients whose muscles have been idle for long periods, so that before leaving for home they know which movements might present problems. When one man was found unable to flick the heavy light switch similar to the one in his own home, he was given exercises to strengthen that particular movement.

Described as the most inexpensive therapy unit in the city, the $70 box is proving its value in detection of muscle weakness. It will save many patients the unnecessary frustration of being defeated by simple household tasks.

Coming of Age

The Junior Hospital Aid of Selkirk General Hospital, Selkirk, Man., has celebrated its 21st birthday. At its birthday party in November there was even a decorated cake with 21 candles.

To Wear Official Uniforms

A new uniform is appearing in the Saint John General Hospital, Saint John, New Brunswick—the red-buttoned, charcoal grey smock which is the official garb of the volunteer workers of women's hospital auxiliaries throughout Canada. For years members of the local Women's Hospital Aid have been designated only by blue ribbon badges, but now that they are carrying out so many duties in the hospital they have decided on the official uniform. The Aid will purchase 36 of the official smocks.

At Hotel Dieu, Kingston

In the above picture Mrs. A. C. Hanley, president of the Ladies' Auxiliary of the Hotel Dieu Hospital, Kingston, Ont., is shown presenting a cheque for $2,129.25 to Sister E. MacPherson, Superior, for equipment donated to the hospital. To the right is Mrs. L. P. Quinn, auxiliary treasurer. This equipment included a wax bath, three infraray lamps, nine utility carts, eight inhalation sets, and two suction machines.

A $500 scholarship was also set up by the auxiliary this past year. It is awarded to an applicant from a secondary school in the district served by the Hotel Dieu Hospital to assist her training at St. Joseph's School of Nursing. The student is paid directly $7.50 each month for 36 months for personal use, $180 at the beginning of the course for initial expenses, and $50 in March of her final year for graduation expenses. The three-year scholarship was won this year by Donna Hunt of Plainfield, Ontario.

For a "Games Month" Success

"Games Month" this past year realized $1,110 for the Ladies' Auxiliary of the Sackville Memorial Hospital, Sackville, N.B. This is even $10 more than the amount raised the year before. These funds are used to replace worn out furnishings and equipment in the hospital.

During the month of October of last year, citizens of Sackville and surrounding communities were asked to organize a table or tables of games, and collect 50 cents from each player. In many of the areas outside Sackville, community parties were held rather than small individual ones. The money was turned over to the games committee, accompanied by the names of those participating. From these lists, names were drawn for 50 prizes donated by merchants and other interested individuals. Besides the income realized from the participants, many cash donations were received from those unable to donate prizes.

Identi-Foto

The Women's Auxiliary of the Royal Victoria Hospital, Montreal, Quebec, has gone into the photography business at the Women's Pavilion of the hospital. The nurses in charge take photographs of newborn babies. The volunteers visit the mothers with the photo packets, take the orders, collect the money, and fill out delivery receipts. For the service the auxiliary receives a percentage of the money.

Coffee by the Gallon

Coffee urns were working overtime, as well as members of the women's auxiliary to the Kitimat Hospital Society in an effort to promote interest in the proposed new hospital at Kitimat, B.C. Free coffee was served on successive

(concluded on page 67)

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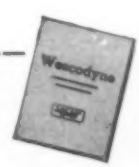

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Auxiliaries

(concluded from page 64)

Friday evenings between six and nine p.m., and hospital equipment was displayed by those members of the auxiliary who are registered nurses.

The Night Shift

The many people who can visit patients only in the evening can now buy a gift and have a cup of coffee at the Hospitality Corner maintained by the Women's Auxiliary of Montreal General Hospital. Women who have full-time jobs during the day are struggling through the five o'clock traffic to don smocks, and become sandwich makers, saleswomen, and—when it comes to the baffling insides of an adding machine—machine repairwomen.

The Evening Volunteers represent the Business and Professional Women's Club, The Mabel Hubbard Club, The Montreal Volunteer Bureau, and the Junior League of Montreal. In the daytime they are stenographers, accountants, receptionists, technical assistants, bookkeepers, school teachers, and busy mothers. From 6:45 until 9 p.m. they work as a cheerful, co-operative unit, keeping the Hospitality Corner open for visitors five nights a week.

Redecoration at Musquodoboit, N.S.

The Musquodoboit Valley Memorial Red Cross Hospital Committee is redecorating the living room and office at the hospital. New curtains will be hung in the living room and in the office. The laundry room will receive a new door and floor covering of battleship linoleum from the proceeds of the Hospital Tea and Barn Dance.

New Auxiliaries East and West

Both Quebec and British Columbia have new hospital auxiliaries this year. The young organization at Cloutier Hospital, Cap de la Madeleine, is under the patronage of Saint Camille de Lellis. In the west is a new hospital auxiliary at Holy Family Hospital, Vancouver.

Alberta Convention

At the 1957 convention of the Associated Auxiliaries of Hospitals of Alberta 45 auxiliaries in the province were represented. "What is an auxiliary for?" was discussed by Dr. J. Crosby Johnston, administrator of Calgary General Hospital, Dr. A. J. Brunet, as a medical director, Ida Johnson, speaking as a nursing superintendent, and Mrs. J. A. McLean, who spoke for the auxiliary members. To answer the general question the panel considered the particular problems of whether or not an auxiliary should assist in buying equipment, provide nursing scholarships, or expect the hospital to provide quarters for their organization.

The Mrs. E. Hammill Bursary was presented, and another of $200 was set up—"The Associated Auxiliaries of Hospitals of Alberta Bursary."

Officers of the Alberta association for this year are: *patrons*, Hon. J. J. Bowlen, M.D., and Hon. E. C. Manning; *Hon. president*, J. D. Ross, M.D.; *past president*, Mrs. E. Wershof, Edmonton; *president*, Mrs. J. Burns, Calgary; *1st vice-president*, Mrs. A. W. Hardy, Edmonton; *2nd vice-president*, Mrs. B. I. Love, Lamont; *corresponding secretary*, Mrs. E. P. Richardson, Calgary; *recording secretary*, Mrs. J. P. Schrader, Olds; *treasurer*, Mrs. W. Hay, Lethbridge; *national vice-president*, Mrs. E. Wershof, Edmonton.

Here and There . . .

India—A Land of Poverty and Suffering

(Dr. Hugh E. Burke, of Montreal, who recently returned from India, was asked to prepare a paper on that country for The National Council of Hospital Auxiliaries of Canada. It was read at their annual meeting where it stirred up interest in an international project, now being studied in detail, to create friendly relationships beyond our own frontiers. We are happy to print his paper here.)

IN an effort to relieve want and misery, the leaders of the peoples of India are striving to raise living standards and to prevent and control diseases such as tuberculosis. India has made some progress in recent years in the matter of improving living standards. It now is producing enough food so that none of its 360 million people need go hungry. The per capita income has been raised from $42 to $50 per year. The peoples of India have been told that tuberculosis can be prevented or, if detected in an early stage, can be successfully treated. Eighty million people have been given tests for tuberculosis and approximately one-quarter of this number have been vaccinated against this disease.

The leaders of India recognize that they do not have anything like the number of trained personnel and of sanatoria for the treatment of persons with tuberculosis that are required. India has only a few physicians who are familiar with Western ways of treating the tuberculous. Many of the too few sanatoria have little equipment other than beds. The staffs of some of even the large sanatoria have to be content with limited laboratory facilities. Physicians working in clinics and sanatoria frequently find that they have to discontinue anti-tuberculosis drug therapy because they have used the last of their current supply, and no more can be obtained from governmental sources, or from anyone, until the start of the next quarter.

The reasons that the leaders of India cannot secure the equipment that is needed for sanatoria and the drugs that are required for the treatment of persons with tuberculosis are: (a) As yet India does not have factories for the manufacture of special hospital equipment; (b) Indians only recently undertook to make streptomycin and isoniazid, and (c) India does not have sufficient exchange to permit purchase outside of the country of all the equipment and the anti-tuberculosis drugs that are required.

We who live in Canada have good reason to be thankful for the high standard of living which we as a people enjoy, and for the facilities for the prevention and control of disease which are ours. One way in which we can manifest gratitude for our blessings is to contribute to present efforts to banish needless misery and suffering among peoples less fortunate than ourselves. Any assistance that we as individuals or as a nation can give the peoples of India at this time will, I feel sure, help to make this world a better place for all mankind.

Homes and Hospital

A unique experiment in combining a housing scheme and a hospital is situated on the southern outskirts of the city of Edinburgh, Scotland. What appears to be an attractive if somewhat unusual housing estate is The Thistle Foundation Settlement, founded at the end of World War II to provide care and treatment for severely disabled veterans in Scotland.

The primary purpose has been to enable the long-term hospital patients to enjoy something of the solace and comfort of home life—to live in houses of their own, surrounded by their own families and belongings—and yet to have available on the spot all the skilled medical attention so essential to their well-being.

Some 120 disabled veterans—men and women—have been received into the settlement since it opened in 1950. The present population, including members of the veterans' families, is 341—123 of them children. So far, 100 houses have been built, surrounded by large, open lawns, and another 40 are planned.

The front door of each house opens into a long and continuous covered corridor leading to a splendidly equipped clinic. Each house consists of a self-contained flat, including a bathroom on the ground floor, with additional bedrooms upstairs. The aim has been to build up a balanced community among the more serious bed cases, the wheel chair cases, and others who, although severely disabled, can move about on their own legs.

Some of the men, even among the wheel chair cases, are able to go out to work, and they are encouraged to do so. But almost all of them need medical treatment of some kind for a long period—in most cases for the rest of their lives.

Full-time employment is provided for men in the settlement who cannot go out to work. They make socks and stockings on machines especially adapted for operation by the disabled. Those who are unable to work regularly are trained in handicrafts and make a wide range of articles, from soft toys, baskets, leather and wooden goods to lampshades.

Extra wide doors and a complete absence of steps permit disabled men in wheel chairs to move easily about the ground floor of the settlement by themselves. At the centre of the 20-acre grounds stands the clinic, the doors of which are opened and closed electrically by pressing a button. These doors open into the same sheltered corridor that communicates directly with every house, so that both patients and nurses can make their way under cover between the homes and the clinic.

The clinic building is the nerve centre of the settlement—with rooms equipped for electrical treatment and physiotherapy. There is a magnificent and especially constructed swimming pool as well as a large gymnasium.

The medical control is in the hands of a council which is advised by a doctor and a panel of medical consultants. An orthopaedic surgeon and a consultant physician attend at the clinic every week to supervise the work of the staff, and resident nurses are available day and night to give help in an emergency as well as day-to-day advice and assistance.

The knowledge that somebody is always at hand to attend to their husbands in case of need enables the veterans' wives to go out more. Every effort is made to encourage the community life of the veterans and their families.

(continued on page 70)

Here and There

(continued from page 68)

Film shows and concerts are held during the winter and in summer there is bowling, archery and basketball.

Sir Francis Tudsbery, a veteran of the first World War, is founder and president of the settlement.—*World Veteran.*

New Maternity Hospital in Brazil Has Bar for Expectant Fathers

The new building of the Associaçao Maternidade de Sao Paulo is an F-shaped 14-storey construction. The basement and ground floor are occupied by administrative offices, out-patient department, laboratories, kitchens, dining-rooms, x-ray department, pharmacy, consulting rooms for different specialists, and a school for expectant mothers. The first floor houses 17 delivery rooms, seven operating theatres with all the ancillary rooms, together with a rest room (containing a bar) where the father and other relatives may wait until the baby is born. The nurseries are on the second floor, and these include several small special nurseries for babies with infections and for premature babies.

The third to tenth floors are similar. They house 300 beds for non-paying patients, divided up into six, four, two and one-bed wards. In addition, part of the building is devoted to private rooms and suites. Some of these suites have a private room for the baby, another for the nurse, another for members of the patient's family who wish to stay with her, as well as a private bathroom and private pantry. This part of the hospital is intended to supply the profits which will enable the hospital to receive a high number of non-paying patients.

Part of the eleventh floor is taken up by a gymnasium where expectant mothers can learn the principles of painless childbirth. —*I.H.F. News Bulletin.*

Courage

As a physician, I have had the happiness of seeing work cure many persons who have suffered from trembling palsy of the soul which results from overmastering doubts, hesitations, vacillations and fear . . . Courage given us by our work is like the self-reliance which Emerson has made forever glorious.—*Richard C. Cabot.*

No Smoking?

A man visiting in the hospital gave his wife a lighted cigarette. A harmless gesture? No indeed, for the wife was in an oxygen tent, and the consequences were serious—death from severe burns and shock. Carelessness? No, for the hospital had hung a proper NO SMOKING sign in a prominent position. Nor was it a case of an unthinking or negligent act on the part of the husband. It was simply that the man could not read English. The sign was no warning to him!

Might not an international system of symbols, such as a sign language, easily understood by all, be the solution to this vital problem?—*Safety Bulletin.*

"A Lunch That Never Was"

"Everyone is so busy these days that another invitation to lunch is often just so much bother," explained Mrs. Julius J. Block, president of the Women's Auxiliary of the Jewish General Hospital, Montreal. "So we hit on this idea of convening an imaginary luncheon and asking our members to send us a dollar instead of coming." The novel idea was so popular with the members that some wrote thank you letters.

Proceeds of the mock luncheon, amounting to $1,100 within three months, will be used to provide tearoom equipment for actual lunches at the nurses' residence of the hospital.

Good Neighbours

We the peoples of the United Nations, determined to save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind, and to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small . . .

And for these ends to practise tolerance and live together in peace with one another as good neighbours . . .

Have resolved to combine our efforts to accomplish these aims.—*Preamble of the Charter of the United Nations generally attributed to Jan Christian Smuts.*

We must be as courteous to a man as we are to a picture, which we are willing to give the advantage of a good light.—*Ralph Waldo Emerson.*

Book Reviews

HOSPITAL ACCREDITATION REFERENCES, by the American Hospital Association, Chicago, Ill. Pp. 136. Price $3.50.

Concise and neat, this volume will be found a very useful handbook on the principles and procedures required for accreditation. It is a systematic compilation of essential data about the accreditation standard, the principles of medical staff government, the explanation of accreditation requirements published by the Joint Commission itself, and further information from articles in hospital periodicals. It publishes for the first time Commission rulings made in reply to specific enquiries—rulings which have been available previously to a very limited audience only.

Hospitals will find very valuable the many samples of specific information required on a surveyor's questionnaire. The history given, although remarkable for its brevity, does make mention of the great contribution of the late Dr. MacEachern, who directed the program for nearly thirty years.

In his preface Dr. Crosby states: "The American Hospital Association, with other organizations of the Joint Commission on Accreditation of Hospitals, believes the accreditation program is one of the most useful instruments yet devised for improving hospital care. The accreditation program is influential and has become a potent force in encouraging good hospital care."

This handbook should help to make the accreditation program a still more "useful instrument". It makes the aims and objects of the program more conveniently available to the constantly growing number of interested hospital trustees, administrators, and medical and ancillary professional staffs.

One could have wished for a more comprehensive volume, such as would have resulted from a complete revision of the *Manual of Hospital Standardization* last published by the American College of Surgeons in a limited circulation in 1946. But perhaps this tidy little book, though less comprehensive, will prove to be more widely read and more frequently used as a reference.—*W. I. Taylor, M.D.*

PRACTICAL NURSING TODAY, Attitudes-Knowledge-Skills. By Margaret C. Esau, Barbara R. Fallon, Kathryn G. Frentzos, Elizabeth C. Phillips and Eleanor A. Tourtillott. Published by G. P. Putnam's Sons, 210 Madison Ave., New York, N.Y. Pp. 527. Price $5.95.

This book has been published in recognition of the advancing importance of the practical nurse on todays' health team, and is directed primarily to the student. Set down in simplified "text book" form for easy and quick assimilation, are facets of nursing needed by the modern practical nurse—from basic anatomy and drugs to flower arranging. The five authors have compiled under one cover the necessary fundamental facts of communicable diseases, hygiene, nutrition and the principles of safe, kindly practical nursing for both home and hospital cases. Special emphasis is placed on pregnancy and child care nursing. Also included is up-to-date information about educational facilities, and practical nurses' associations in the United States.

The student practical nurse in Canada, as well as her instructors and supervisors might well find this book a useful guide, and perhaps might find in it motivation to keep in step with their up and coming field.

FINANCIAL ASPECTS OF HEALTH INSURANCE, by Malcom G. Taylor, M.D. Published by the Canadian Tax Foundation, Toronto. Pp. 120. Price, per single copy $2.00; 10 copies $15.00.

The Canadian Tax Foundation asked Professor Taylor to prepare an analysis of the financial aspects of existing governmental health schemes and to make some limited forecast of the financial implications of possible future health measures. This the author has done in a readable book containing six chapters, 50 tables and a useful bibliography. Chapter headings are: The Impact of Illness, Health Resources and Expenditures, Financial Aspects of Voluntary Insurance, Financial Aspects of Government Programs, The Federal Government Proposals, and Financial Implications.

Professor Malcolm G. Taylor of the University of Toronto is eminently qualified to write this type of book. He is recognized as one of the chief authorities in Canada on hospital insurance and his experience embraces both the practical and the theoretical side of the subject. He was closely associated with the establishment of the Saskatchewan Hospital Services plan and has acted as advisor to both the provinces of Ontario and Manitoba on hospital insurance programs. His book, *The Administration of Health Insurance in Canada*, published in 1956, has been widely read by hospital and governmental people.

The over-all story of hospital insurance is changing rapidly at the present time. *Financial Aspects of Health Insurance* contains much up-to-date information which will be of assistance to administrators, trustees, and all concerned with the financial aspect of health insurance.

A GUIDE FOR PSYCHIATRIC AIDES. By Charlotte R. Rodeman. Published by Brett-Macmillan Ltd., Toronto, and the Macmillan Company, New York, 1956. Pp. 234. Price $3.95.

To be of help to the patient the psychiatric aide himself must be healthy and well-adjusted. As constant guide and interested listener, the aide must learn to not condemn the patient's behaviour but to understand and accept it, and to help him to improve.

Miss Rodeman recognizes the apprehension naturally felt by an untrained aide. She suggests topics of conversation to help both patient and aide over the "getting-to-know-you" stage. Some questions should be answered only by the doctor, she counsels; and the aide is to report rather than interpret the patient's behaviour for the doctor.

The aide must protect the patient from his own illness—from suicide, escape, and hazardous articles. The book prepares the aide to meet the untoward behaviour, mental and physical, which arises

(concluded on page 74)

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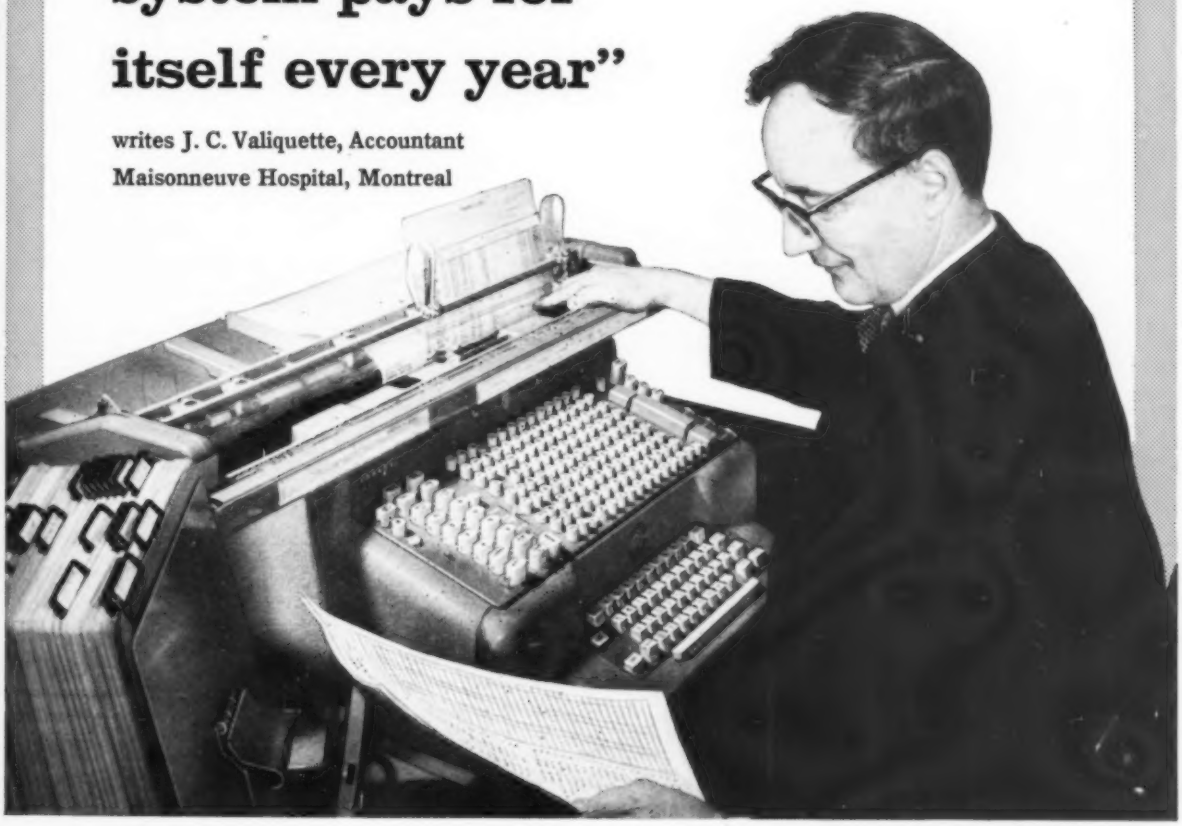
writes J. C. Valiquette, Accountant
Maisonneuve Hospital, Montreal



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from the patient's mental condition. There are practical directions for maintaining his physical well-being. She explains the reasons behind the behaviour of patients who are under- or overactive, withdrawn, suffer delusions or imagined illnesses. Different types of seizures and their treatments are outlined, special therapy procedures described, and charts provided. Simply and directly, she tells the aide how to perform basic nursing procedures without alarming the patient, and concludes with a helpful list of words the aide should know.

Miss Rodeman has given practical instruction and basic information where it can be well used —she speaks directly to the psychiatric aide.

PATTERNS AND PRINCIPLES FOR HOSPITAL AUXILIARIES. Published by the American Hospital Association, Chicago, Ill., 1957. Pp. 56. Price $1.50.

Whether the auxiliary makes public relations, volunteer service, or fund raising its primary purpose should depend on the hospital's need, we are told immediately. "Always remember that the auxiliary exists for the hospital, not the hospital for the auxiliary."

This new manual was written to replace *Organization of Women's Hospital Auxiliaries*, and its supplement, *Organizing a Hospital Auxiliary*, also published by the A.H.A. It outlines the steps of organizing a new auxiliary. It suggests by-laws to be adopted, and committees to be set up, outlining the duties of the officers. Quality control of membership is discussed, as well as dues, age limits, uniforms and ensignia. To have an informed membership a committee should be organized, responsible for information and orientation.

A chapter is devoted to leadership—finding it, training it, and holding it. The operating policies outlined emphasize recognition of the authority of the administrator, and sound business procedures as methods of maintaining organizational stability.

Although there are three chapters entirely on the organization of the American association, there is much in this manual that could be adapted to individual needs to make it a help in organizing new groups, and a check and further guide to existing auxiliaries in Canada.

MORAL HANDBOOK OF NURSING. By Rev. E. J. Hayes, Rev. P. J. Hayes, and Dorothy E. Kelly, R.N. Published by Brett-Macmillan Ltd., Toronto, and the Macmillan Company, New York, 1956. Pp. 180. Price $2.95.

Even a conscientious Roman Catholic nurse cannot always consult a priest when an ethical problem arises in her work; sometimes she must act at once. This manual was written by two priests and a nurse so that she may be familiar with the Roman Catholic principles of ethics pertinent to her professional duties, and able to apply them to herself and the problem situations she encounters.

It's tough to make a mistake, and it's tougher still if we find out that we're so unimportant that nobody noticed it. — *The English Digest.*

1917

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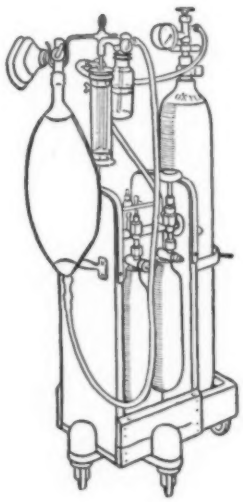

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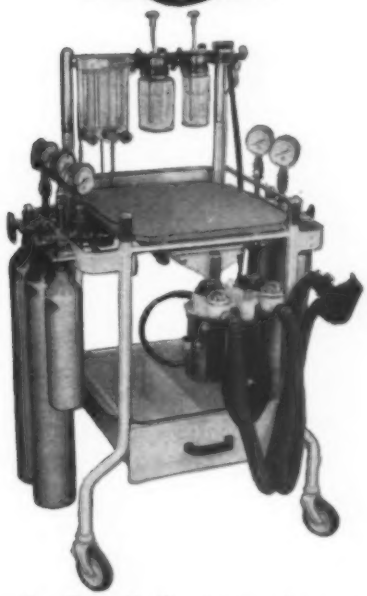

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Provincial Notes

Nova Scotia

Sutherland Memorial Hospital, Pictou, will receive $5,000 from the estate of Elizabeth L. Hubard of Norfolk, Virginia.

The Hospitallers of Saint Joseph are planning a new hospital for Yarmouth. It is to contain at least 100 beds, 75 of them for active treatment cases, and a separate wing for rehabilitation and chronic cases.

The Lillian Fraser Memorial Hospital, Tatamagouche, formerly a Canadian Red Cross Hospital, became an independent institution last month. It has been transferred to community ownership.

Sale of Annapolis Valley apples by Rotarians of Dartmouth resulted in the presentation of three television sets to the Nova Scotia Hospital, Halifax.

Colchester County Hospital, Truro, is to have a new laboratory —bigger and better equipped, by revamping the present sewing and maintenance rooms.

New Brunswick

A new wing is to be erected at the Miramichi Hospital, Newcastle. The estimated cost of $175,000 also includes improvements to the present building.

On the first floor of the new $200,000 addition to Evangeline Maternity Hospital, Saint John, N.B., there will be a clinical laboratory, dining room, kitchen, laundry, sewing, boiler and laundry rooms. On the second floor will be four wards, a nursery, and isolation rooms. Architects Alward and Gillies have received tenders, and are seeking completion by early summer.

Quebec

A $300,000 gift from an anonymous French-Canadian donor heads the list of contributions to the recently opened St. Justine's Hospital for children in Montreal. A bed was purchased and will be maintained for one year by a $2,500 donation from the Richelieu Club of Verdun. The Provincial State Council of the Knights of Columbus also donated $2,500.

A junior wheel chair was presented to the children's ward of Sherbrooke Hospital by friends of the late Rev. Norman McLeod of Lennoxville.

Five television sets were given to St. Michel-Archange Hospital, Quebec City, by the local Kinsmen club. The Province of Quebec Football Association presented a cheque for $500 to the Montreal General Hospital for the upkeep of an endowed bed.

The Julius Richardson Convalescent Hospital, Montreal, although it was erected in 1952 for convalescing children, is admitting increased numbers of adults. Some of the junior beds and plumbing equipment have been exchanged for the senior type.

Ontario

A six-bed combined hospital and diagnostic centre has been opened at Virgil. The licensed private hospital is the work of three immigrant doctors who are now Canadians.

Victoria Hospital, London, has firmly re-established a "catastrophe fund" to assist patients who are overwhelmed by hospital bills for special services. It was originally set up by a bequest several years ago; and is now to be carried by the hospital itself. The hospital has also received $4,300 from the J. P. Bickell Foundation for the allergy clinic.

The sod has been turned for the new wing of Cobourg General Hospital. Plans for the $1,036,000 addition were drawn up by architects Drever and Smith, Kingston.

Ottawa Civic Hospital is suggesting to visitors that, instead of bringing flowers or candy to friends in hospital, they could use the money to help pay the hospital bill. The gift certificate plan arose as the trustees were discussing how to collect outstanding bills.

Facilities for cardiac diagnosis at Hamilton General Hospitals will be expanded by the grant of $13,403 from the Atkinson Charitable Foundation. With the new eight-channel recorder and an oximeter the hospital will be able to carry out twice as many catheterizations as before.

Metropolitan General Hospital, Windsor, has received $7,849.95 from the Atkinson Foundation. This will provide equipment for an isotope laboratory for diagnosis of thyroid tumors and anaemia, and an electro-encephalography laboratory for diagnosing brain disorders.

Meaford General Hospital receives $20,000 in the will of the late Mackenzie Robertson, and $1,000 from the estate of Kate Davidson, for many years a town official.

The Toronto Orthopaedic Hospital, which has been operating for three years as a private institution for treatment of bone injuries and disorders, will become a public orthopaedic hospital. It now contains 20 beds, an operating room, therapy facilities, a splint and brace shop, and a patients' lounge. A new building is planned for the site to increase its size by two and one-half times. It is to be called the Arthritic and Orthopaedic Hospital.

The School of Nursing at Guelph General Hospital has been officially opened. (See The Canadian Hospital, April, 1957, page 50.) The new building occupies the site of the former General Hospital, unused since 1951 and now demolished.

Work on the 100-bed hospital for Bruce Mines is now underway, and is expected to be ready for occupancy by spring of 1959. Half of the funds for the $2,000,000 project has been contributed by mining companies.

Manitoba

The new Cornish wing of Misericordia General Hospital, Winnipeg, now officially opened, has seven floors. On the first floor are the hospital's admitting and administration offices; on the second are patient wards. The third floor has 64 bassinets, incubators, eight labour rooms, and three delivery rooms for maternity cases. The fourth is dedicated to surgery, the fifth to patient wards,

and the sixth to paediatrics and psychiatry. On "the roof", the incomplete seventh floor is a glassed-in sun room. The wing was constructed at a cost of $4,250,000.

A new x-ray machine was turned over to Portage General Hospital, Portage La Prairie, by the Sanatorium Board of Manitoba. This machine, operated by one person, is faster and more economical. Its speed cuts down the amount of radiation required considerably.

Brandon General Hospital has received from local Kinsmen the first installment of their $30,000 pledge to complete a new obstetrical suite at the hospital.

The town of Souris is loaning $7,000 to the governing board of Souris Hospital Area No. 11 for construction and equipment of an x-ray laboratory.

The new hospital at Shoal Lake will serve two villages and four municipalities. It has 20 adult beds, four children's beds, a nursery, and two operating rooms, and will cost about $80,000. Two former hospitals were destroyed by fire, one in 1929 and the other 1954.

Saskatchewan

Moosomin Union Hospital District has approved spending of $100,000 for a ten-bed hospital at Whitewood.

A 20-bed hospital is to be built at La Ronge. Provincial and federal governments will share in the estimated cost of $350,000.

Accommodations for 60 male nurses at the Saskatchewan Hospital, Weyburn, have been completely renovated at a cost of $250,000.

Patients were occupying the new 80-bed wing of Saskatoon City Hospital even before it was completed. When the cafeteria and nursing stations have been rebuilt, cost of the expansion program is expected to be $2,200,000.

Alberta

The Red Cross Crippled Children's Hospital at Calgary will now be directed by a committee of five private citizens as a community project. The Red Cross has operated the hospital for 35 years.

Leoville Union Hospital, Leoville, is to be enlarged and its existing facilities improved. An

(concluded on page 78)

Provincial Notes
(concluded from page 77)

extension will provide 12 beds, and the present structure will be converted into an operating room, a case room, and diagnostic and out-patient facilities. The second floor will be staff accommodation.

Medicine Hat's new 243-bed municipal hospital and 106-bed nurses' residence have been officially opened. The two structures totalled $3,500,000 in cost. Architects were Rule, Wynn and Rule, Calgary.

A hydraulic "porto-lift" has been donated to the Red Deer Municipal Hospital by the local branch of the Canadian Legion. Presentation of a wheel chair to the Royal Alexandra Hospital, Edmonton, marks the first step in the program of the women's auxiliary to the Brotherhood of Locomotive Engineers. They plan to present gifts to each Edmonton hospital in turn.

Although the new nursing home by-law in Calgary is more rigid than the former statute, it was welcomed by most of the city's nursing homes. It requires that at least minimum services and facilities be provided for the safety and comfort of the patients. Violations will bring a $500 fine.

British Columbia

Final step in demolition of Quesnel's original hospital building took place when the rubble left after it was torn down was set ablaze by the local fire brigade as part of their practice.

A new 283-bed North Vancouver Hospital is to be built on the North Shore, to serve North Vancouver City and district, and the district of West Vancouver. Architects are Underwood, McKinley, Cameron, of Vancouver.

Kootenay Lake General Hospital, Nelson, is now participating in the regional pathologist service.

Plans for the 22-bed frame hospital to be built at Golden have been drawn by architects Smith and McCulloch of Trail.

A 10-acre tract of land has been acquired by the Sisters of Providence as a site for the proposed new hospital at Dawson Creek.

The Clinical Investigation Unit of St. Paul's Hospital, Vancouver, has received $10,500 from the Kinsmen-sponsored B. C. Child Care and Polio Fund. One piece of equipment purchased is a heart-lung machine which enables the surgeon to divert blood flow around the patient's heart during surgery.

Patients as well as hospital administrators and staff approve

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Twenty Years Ago

From the Canadian Hospital, February, 1938

It is of considerable interest to note the official pronouncements of hospital and medical organizations respecting group hospitalization. The American Hospital Association in 1933 endorsed the principle and formulated a series of essential stipulations. In 1934 the American College of Surgeons approved the general principle also. The Catholic Hospital Association has been very cautious in its resolutions for some time, but this year agreed that it "now desires to encourage its members to subscribe . . . ". The Canadian Medical Association, which has had a special committee studying group hospitalization for some time, has approved group hospitalization as "fundamentally sound". The American Medical Association has not officially endorsed nor disapproved of it, although its general attitude in previous years was in opposition.

One of the most desirable developments of recent years has been the creation of the Committee on Hospital Service of the American Hospital Association, under the chairmanship of Dr. Basil C. McLean and with C. Rufus Rorem, Ph.D, C.P.A., as full-time director. Subsidized by the Rosenwald Fund this committee is making a careful analysis of the present trends, and is doing much to mould the newer plans. It is of particular value as a tie-in between the hospitals and these various plans, a tie-in of value of which may become more apparent in years to come, for there is a very potential danger of these movements running away with themselves and, unlikely as it would seem now, taking a dictatorial attitude to both the hospitals and the professions. For that reason it is essential that the hospitals and the medical profession link in with those movements.

The future is not entirely clear. Undoubtedly there will be success for the immediate future. One would anticipate a greater inclusion of dependents and a gradual extension of benefits, as reserves prove adequate. One would anticipate also a general demand for inclusion of medical and nursing care. One can foresee a possible amalgamation or merger of many local plans into one large organization.

"A foul and pestilent congregation of vapours"

Seven o'clock on a Wednesday morning in February is probably the most unhealthy time to "take the air" in a Canadian industrial city. This is the conclusion drawn by smog prevention experts from a long-term survey in the Windsor, Ontario area.

Dr. Katz, Air Pollution Consultant to the Department of Health and Welfare, said that the cleanest air is likely to be found at about 2 o'clock on a midsummer Sunday afternoon. Pollution shows a marked increase during the winter months, toward the middle of the week and between 2 a.m. and 9 a.m.

Paracelsus

As an excellent clinician who was above all occupied with the welfare of his patients and who had compassion for the poor, Paracelsus was basically a representative of social medicine.—*René Sand.*

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Toronto Society for Crippled Civilians

This society has been in operation for 21 years, offering its varied services to thousands of handicapped men and women. It has rendered nearly 20,000 services to the handicapped. A non-profit organization, the society has grown from one employee in 1935 to 200 in 1956. It is more than 90 per cent self-supporting through the efforts of the cripples themselves. Nearly three and a half million dollars make up the total receipts and earnings to date; and over two million dollars in wages have been paid out. A Homebound Department with a registration of 800 operates for shut-ins—150 of these are provided with work. Marina Creations, a division of the Homebound Department, employs 33 handicapped persons who produce deluxe articles of excellent workmanship. Supplies, orthopaedic appliances, wheelchairs, crutches and canes, artificial legs and arms are made available by the society to those who cannot afford such requisites. — *21st Annual Report of the Toronto Society for Crippled Civilians.*

New Hospitals for the Bantus

"It has been decided to build in the Transvaal, for the Bantus, four new hospitals, at a cost of 4,000,000,000 francs", administrator D. Nicol has stated. Plans are already well advanced for construction of the first two hospitals. One will be situated close to Johannesburg and the other in Pretoria. At the present time, about 60,000 beds are reserved for indigent patients in 51 provincial hospitals of the Transvaal. It is forecast that next year, about 5,000,000,000 francs will be spent on indigent patients in Transvaal hospitals. These four new hospitals will bring to 7,000,000,000 the sum spent each year on the hospitalization of indigents. — *Translated from Techniques Hospitalières.*

Small Pox Threat

No less than eighteen countries were infected with small pox by international travellers during 1956. As a result, eight countries suffered epidemics, according to the World Health Organization Committee on International Quarantine. At a recent meeting in Geneva, the committee warned against any relaxation of vaccination measures against small pox and called for the use of potent vaccines as well as correct vaccination procedures. The committee expressed the need for medical and other personnel who come in contact with travellers to maintain a high level of immunity against small pox by repeated vaccination. In the course of these recent epidemics some doctors treating tourists caught the infection and died. — *Pan American Sanitary Bureau.*

More Precious

In New York, the law forbids fingerprinting of potential employees of voluntary non-profit hospitals as a screen against criminals.

In New York, the law permits the fingerprinting of potential employees of "a public gallery of art or museum housing valuable objects of art, precious metals or precious stones, supported in whole or in part by public funds or private endowments."

Moral: in New York, it is better to be a dead Goya than a live guy. —*Hospitals.*

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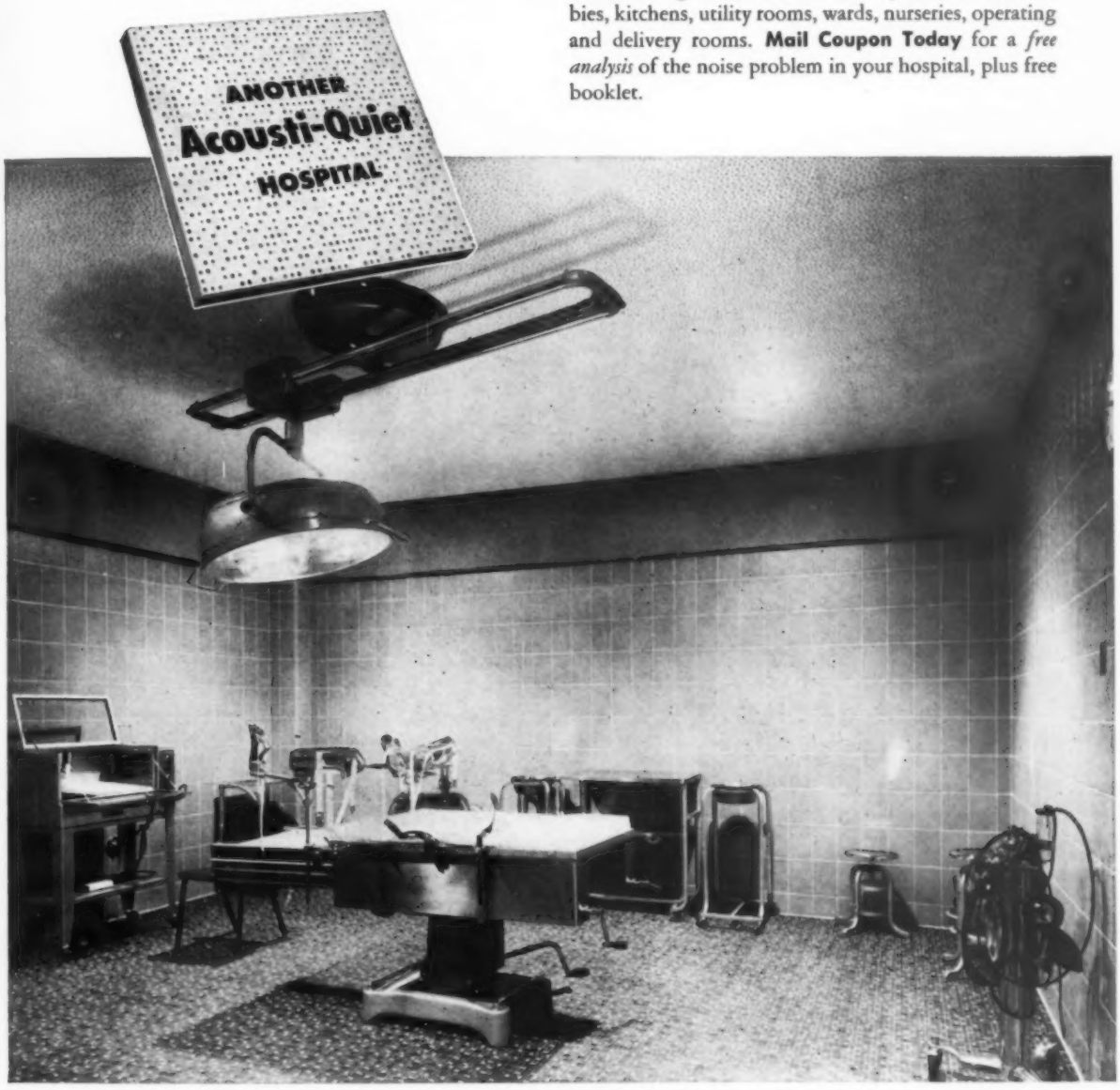

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Telephone Admitting

A plan for streamlining the admitting of elective patients has been outlined in a recent report in the *Bulletin* of the British Columbia Hospital Insurance Service by M. A. M. Fraser, assistant administrator of the Royal Jubilee Hospital, Victoria, B.C. Mr. Fraser's report is as follows:

For some time we have pondered ways and means of improving and speeding up the actual admission of our patients to hospital, and the related procedures associated with admission. We tried using pre-admission forms in hope of obtaining the data needed to complete our Admission and Discharge Form (BCHIS form HIA 18) in advance of the patient's arrival at our hospital. This method of obtaining our admission data was unsuccessful. It proved to be too slow, distribution through the doctors' offices was not satisfactory, mailing the form was also unsatisfactory in that forms were not returned by many patients and those forms which were returned were frequently inaccurately completed.

We finally resorted to what now appears a most obvious method of obtaining the data required, namely, telephone admitting. The procedure is as simple as this. The bed is booked by the attending doctor or by his office nurse, at which time the address and telephone number of the patient is given to the admitting officer. Prior to the time the patient is to be brought into hospital, an admitting officer telephones the patient (or relative), explains the purpose of the call, and requests the information required. The patient, upon arrival at the hospital, has little more to do than sign the completed admission form and conclude any necessary financial arrangements. This uncomplicated procedure has virtually revolutionized the physical admission of our patients. Approximately 90 per cent of our patients are so admitted and the delay in getting the patient to his room has been reduced to a minimum. Our patients, without exception to date, appreciate the opportunity to give us the data we require from their homes, and to have questions concerning what they will need during their stay in hospital, et cetera, answered prior to their arrival. This procedure has also effectively reduced the pressure on the admitting officers. Our patients are happier and our employees are happier since the introduction of our telephone admitting procedure.

Interlingua

Interlingua, a new international language for scientists, was employed in written form to streamline sessions of the Ninth International Congress on Rheumatic Disease.

It supplements the four official languages of the congress — English, French, German and Spanish. Interlingua is the product of 17 years' effort by academies of science in four countries. It incorporates about 100,000 words common to English, French, Italian, Portuguese and Spanish, and embodies scientific terms which are derivatives of Greek and Latin. —*The Globe and Mail.*

Everybody wants to live longer, but nobody wants to grow old. —*Jules Rostand.*

Wanted: Record Librarian
(continued from page 54)

These five items comprise the work actually done by the librarian in the record room. Finally, I shall mention the manner in which the librarian conveys this information to the administrator. The librarian should give the administrator a monthly report of the number of patients discharged, patient days, average stay, deaths, autopsies, complications, institutional infections, and consultations. The information should be presented both with regard to total patients, and subdivided according to the various services which may be simply medical, surgical, obstetric, newborn and pediatric in a small hospital.

At given intervals, or on request, she should be able to provide the administrator with a similar summary relative to each member of the medical staff.

Reports should be provided also, on such important matters as removal of normal tissue other than plastic and repair surgery; and on details of complications and institutional infections. To compile these reports requires some special training and experience. The librarian must be sure of her standards for judging institutional infections. If she does not take advice from the medical staff when in doubt, the data will be erroneous and misleading. Properly compiled, this information is of great value to the administrator and board of management, in showing them weaknesses in the medical and nursing care which they may be able to correct.

With regard to these reports for the board of management, it is the administrator's duty to insist that the librarian present them as neatly and attractively as possible. This is more important than it seems. The special reason why statistical and other medical record reports should be well set up is that so many persons tend to close their minds to data concerning medical services. Your board members may feel incapable of digesting such material; but it must be presented to them at given intervals, so that they may gradually acquire some real interest in it. It is the board members who are ultimately responsible for the medical care in the hospital. If reports are carelessly drawn up and difficult to read, they will have reason to feel that they are presented as a mere matter of form. Personally, I just can't get myself to read an indistinct carbon copy of anything unless I absolutely have to; and I am convinced that the time spent on producing such copies is pure waste. It is better by far to spend twice as much time and make the reports presentable, for then you have reason to hope that sooner or later the board members will realize that they are expected to take notice of them. I emphasize this because too often girls just out of business school seem to have no idea of how to set up a report. When administrators demand a high standard of typing and reporting from their stenographers, they do them a favour. Without such incentive, people lose both efficiency and job-satisfaction; but with some urging, they increase their proficiency and become happier and more valuable workers.

When the administrator has a person with the right character for the job in medical records with the basic training outlined, he

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Wanted: Record Librarian
(concluded from page 86)

should give her a fairly free hand and let her feel that her primary duty is to records. To organize a department, a young woman must have time to think and plan, and time to present her problems. She should not be overburdened with other routine jobs such as developing x-ray films. This shows a certain lack of understanding between management and librarian, and a certain weakness on the part of the latter in that evidently she did not "sell" her job sufficiently to the hospital superintendent.

Good understanding between administration and the librarian is essential. There may be differences of opinion, but the relations should always be based on loyalty, sincerity, mutual respect and personal regard. The administrator should realize that the medical record department is a source of information which may well be regarded as the key to knowledge of what is going on in his institution. The librarian, on her part, must always bear in mind that she is working for the administration, *not* for the medical staff, and her loyalty is primarily towards the former, while she maintains good and discreet personal relations with everyone else.

This good understanding will be a source of strength and encouragement to the librarian, and will make it possible for her to contribute as she should to the great end of the hospital—better patient care.

The Hemiplegic
(concluded from page 52)

any re-training for a number of weeks, but then gradually recover the ability to co-operate in feeding and dressing themselves and later to manage these alone. Prolonged supervised care is essential for such cases. They should be in an environment where they are encouraged in learning independence especially by example from other patients. Elderly patients cannot tolerate intensive physiotherapy but require simple exercises frequently repeated during the day. This can be given most easily with a group of patients receiving treatment on the ward, where they can go at a leisurely pace and also show others, who are less advanced, what is expected.

Summary:

Since hemiplegia due to cerebral vascular disease is a common condition, most general hospitals are requested to accept such cases for investigation and treatment. With a rehabilitation program a large proportion of the survivors of the initial catastrophe will regain personal independence and can be discharged from hospital. Such a program does not require expensive equipment but a co-ordinated effort by nursing staff, physiotherapist and occupational therapist (if available), under the direction of the physician.

A baby sardine was swimming happily along with his mother when he saw his first submarine. Frightened, he swam to his mother's side.

"Don't worry, dear," she said, "it's just a can of people."—*Davis' Nursing Survey.*

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In the light of the essential rôle being played by pharmacy today, it is anomalous that fewer than 30 per cent of hospitals of over 50 beds, in the province of Ontario, for instance, should have qualified pharmaceutical service. I believe a move is now under way to improve this situation.—*Dean F. N. Hughes in the Bulletin of the Ontario College of Pharmacy.*

If children grew up according to early indications, we should have nothing but geniuses.—*Goethe*

Packed in order of use—This new pre-pack is put up so the patient gets her supplies in the order of use. Opening the bag, the patient draws out first the four cotton balls for perineal cleansing. Then the napkin, carefully folded to protect its sterility. And directions for patient's use are printed right on the bag.

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Coming Conventions

Mar. 3-6—Joint Nurses-Surgeons meeting sponsored by the American College of Surgeons, Commodore Hotel, New York City.

Apr. 14-16—College of General Practice of Canada, second annual scientific assembly, Royal Alexandra Hotel, Winnipeg, Man.

June 12-14—Canadian Association of Physical Medicine and Rehabilitation, annual meeting, Quebec City, P.Q.

June 16-20—Canadian Medical Association Convention, Nova Scotian Hotel, Halifax, N.S.

June 17-20—16th annual convention of the Canadian Society of Radiological Technicians, Fort Garry Hotel, Winnipeg, Man.

June 21-22—Conference of Catholic Schools of Nursing, annual meeting, Atlantic City, N.J.

June 21-26—Catholic Hospital Association of the United States and Canada, annual convention, Atlantic City, N.J.

June 23-27—Canadian Nurses' Association 50th Anniversary Meeting, Lansdowne Park, Ottawa, Ontario.

June 25-27—Comité des Hôpitaux du Québec, annual convention and commercial and scientific exhibition, Montreal Show Mart, Montreal, P.Q.

Oct. 15-17—The Saskatchewan Hospital Association, annual meeting and institute, Bessborough Hotel, Saskatoon, Sask.

Oct. 21-23—Annual convention of the Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alta.

Oct. 28-31—Annual convention of the B.C. Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Meaning of Education

By education I do not mean learning for learning's sake, but education to train the mind to think, to reason, to explore, and above all to continue to educate itself so that there will be created a well of knowledge from which to draw not only inspiration but the technique of performance and production. Those who have been taught that one must think, read, relentlessly pursue the quest of knowledge, and that knowledge is largely useless if not applied, are fortunate men and women.—*J. Muir in "The Royal Bank of Canada Monthly Letter."*

Simplicity

We ought to say what we have to say in the simple, unadorned words of every day language. We could cook up some gobbledygook such as the following:

"Undue multiplicity of personnel assigned either concurrently or consecutively to a single function involves deterioration of quality in the resultant product as compared with the product of an exact sufficiency of personnel." Or we can say, "Too many cooks spoil the broth."—*Robert B. Meyner, Governor of New Jersey.*

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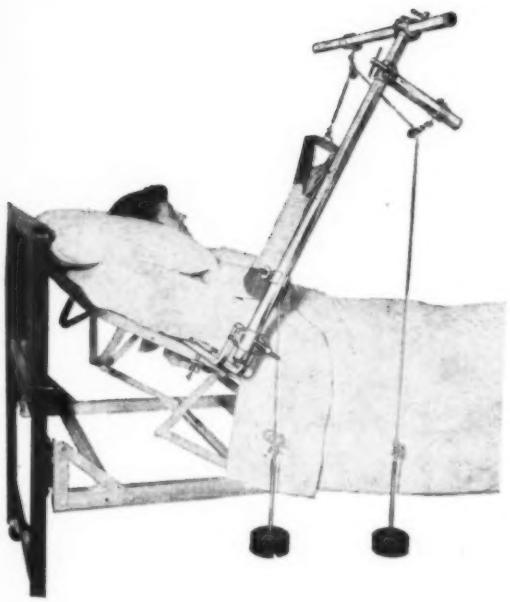

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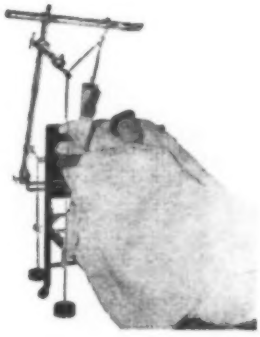

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à cet effet. La qualité des soins étant son principal objet, la Commission Mixte s'intéresse particulièrement à l'organisation du corps médical, aux pratiques médicales en vigueur dans l'hôpital, à la qualité des archives médicales et aux départements qui contribuent directement à la qualité des dits soins. La seule façon pour vous de savoir quel est le niveau de votre établissement par rapport aux autres à ces divers points de vue, est de le faire examiner. Si votre hôpital a fait l'objet d'une étude et n'a pas été accrédité, les raisons en auront été fournies par la Commission Mixte. Il s'agit alors de faire votre possible pour parer aux insuffisances révélées par l'examen.

Le programme d'accréditation par la Commission Mixte est en vigueur depuis plusieurs années. Il vient en droite ligne de l'ancien Programme de Standardisation des Hôpitaux du Collège Américain des Chirurgiens (Hospital Standardization Program of the American College of Surgeons), qui a fonctionné pendant une trentaine d'années.

Le fait qu'un hôpital de plus de 25 lits n'ait jamais cherché à faire étudier son cas implique que cet hôpital ne se préoccupe pas de fournir des soins de qualité. Il devrait y avoir là matière à réflexion pour le conseil d'administration qui, en fin de compte, en est responsable envers la communauté.

La majorité des hospitaliers estime que l'accréditation est un objectif important pour n'importe quel hôpital. Nous pensons que, vu l'activité de la Commission Mixte d'Accréditation des Hôpitaux depuis 1952, les corps médicaux, conseils d'administration et services administratifs des hôpitaux sont maintenant relativement familiarisés avec les standards de la Commission Mixte. On se demande pourquoi il y a encore de l'inertie a dit le Dr. J. B. Neilson, Trésorier de la Commission Canadienne d'Accréditation des Hôpitaux, s'adressant au 33 ième congrès de l'Association des Hôpitaux de l'Ontario.

"Les progrès du programme d'accréditation nécessitent de la part des hôpitaux beaucoup plus d'enthousiasme qu'ils n'en ont montré dans le passé. Il n'existe pas de voie facile menant à l'accréditation car il n'y a pas de limite à l'amélioration des soins. Vous reconnaissez, je pense, que la récompense est digne de l'effort, et qu'un hôpital portant le sceau de l'accréditation est un hôpital qui peut mériter à juste titre le respect et la confiance de la communauté qu'il déssert."

L'Accréditation est un mouvement unique en son genre, et dont l'influence s'accroit en Amérique du Nord. Il y a beaucoup à dire en faveur du maintien du caractère volontaire de ce programme, patronné et mis en oeuvre par les organisations médicales et hospitalières elles-mêmes. D'un autre côté, si les organisations hospitalières et médicales ne peuvent amener leurs membres à s'intéresser à la question, il est normal de s'attendre à ce que—vu l'importance croissante des fonds publics dans le financement des hôpitaux—l'accréditation des hôpitaux cesse un jour ou l'autre d'être un programme éducatif librement accepté et devienne une fonction du gouvernement.

En 1958 nous aimerions voir les hôpitaux, particulièrement ceux de 25 à 100 lits, accorder beaucoup plus d'importance à l'accréditation en tant que moyen d'amélioration de la qualité des soins aux malades.

Psychological Rehab.

(continued from page 36)

now, he had lost any determination to live. More surgery might help, more medication might help, but these measures alone would not be likely to do any better in the future than they had done in the past unless *all* the factors of his illness, the psychological factors in particular, were taken into account and included in the rehabilitation program.

I mentioned three things, psychologically speaking, that this patient had lost and which were evidently the determining factors in the unsatisfactory course of his illness. These same three factors—confidence, desire and determination—are probably the most important psychological factors in the rehabilitation of any patient.

Every doctor knows that a confident patient gets well better than a dismal, pessimistic patient. What the patient expects to happen influences, to some extent, what does happen. Confidence, or expectation, or faith has moved mountains of disability. Anything that restores a patient's confidence in his physical abilities goes a long way to restoring those abilities. That is why occupational therapy plays such a vital rôle in rehabilitation. As the patient is led to try renewed activity, it gives him not simply practice but also confidence in a sense of progressive achievement.

Mr. A. had lost confidence in himself, and, more than that, he had lost the desire to be well. But, does not everybody want to be well? The answer is yes and no. On the surface, the patient almost certainly would want to be well. But superficial, conscious desires may not represent the bulk of underlying inclinations. What appears on the surface, as with the ice berg, is only a very small part. What lies below the surface—below the surface of consciousness—may determine the direction in which the patient goes. For the ice berg, with its greater bulk under the surface, it is the tide, not the wind above the surface, which determines the direction in which it moves. Similarly with the patient, on the surface he may want to be well, but there may be much underneath the surface of consciousness that determines that he really does not want to be well. In the complexity of personality, these attitudes and motives are always mixed. Fears and despairs may create such an undertow that the

(concluded on page 102)

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Psychological Rehab.

(concluded from page 100)

patient's conscious wish to be better may be negated.

A person's deep set desire to be well or to remain ill is a very complex thing to deal with. Only by helping the patient to deal with his underlying fears or despairs can he have a concerted wish to be well. This calls for specialized psychiatric supervision in the course of over-all rehabilitation.

A patient may have a fair degree of confidence and an over-all desire to be well, yet much may depend on a third element—his determination to be well. A complete absence of the will to live can lead actually to death. It is rarely c o m p l e t e; but it is often appreciable. It is despair, in particular, that devastates the will. Some degree of despair is perfectly understandable and quite appropriate for a patient stricken with a severe disability. Sometimes the despair grows out of all proportion to the actual situation. Thus a state of depression may develop which becomes an illness in itself—a psychological illness—and may require specific treatment. In such cases general measures of rehabilitation would otherwise be ineffective.

With some patients the lack of determination to get well may stem not so much from despair as from an inherent defect of character which may be traced through as a life-long pattern—an inability to cope effectively with any appreciable stress in life. This is a more profound problem calling for long-term psychological treatment involving many or all members of the medical rehabilitation team concerned with the patient.

Mr. A., like so many chronically ill patients had lost his confidence, his desire and determination to be well. His ill health extended much further than his stomach. Remember Plato's words, "if the head and the body are to be well, you must begin by curing the mind: that is the first thing".

Fair Play

After receiving $800 for the loss of her jewellery, an elderly woman wrote to her insurance company that it had been found in a cupboard. "I didn't think it would be fair to keep both the jewels and the money," she added, "so I thought you would be pleased to know that I have sent the $800 to the Red Cross." — *Wall Street Journal.*

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Intensive Therapy Curtails Commitment

The enormous and growing population of aging persons has become a matter of extensive official concern by reason of the fact that half the residents of mental institutions are past 65. Controlled studies reported by Dr. Lionel Z. Cosin of Oxford, England, showed that the Cowley Road Hospital at Oxford was able to admit 125 older persons with severe mental disorders warranting commitment, by setting aside a few beds for intensive treatment. Only four had to be committed to mental hospitals. Cosin believes that this method of therapy has cut the admissions to mental hospitals by 80 per cent for patients over 65. Many of the mental aberrations are caused by simple circulatory deficiency and most of the patients respond to good medical management in 20, 30, or 40 days.—*Harald M. Graning, M.D., U.S.P.H.S., in "Public Health Reports."*

Mothers As Nurses

The children's department of the general hospital in Tuzla, Yugoslavia, does not house children only. Besides the 130 beds for children there are 40 beds in the department for mothers. To increase the number able to be admitted, in some cases mother and child share one bed.

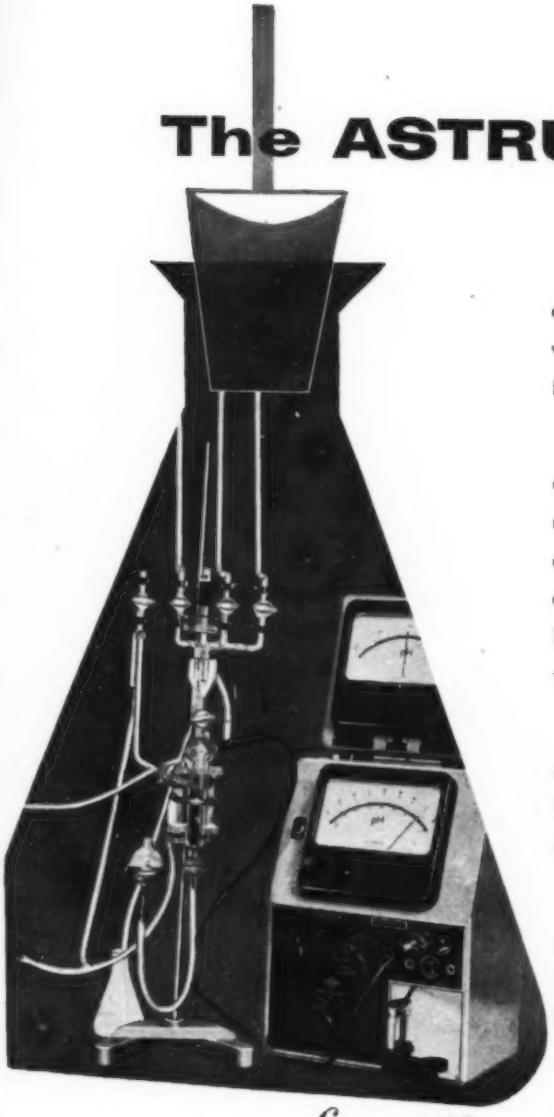
The first advantage of this system is that fewer nurses are required. The mother looks after the child's feeding, bed, and hygiene. It also helps the child emotionally. Children who do not feel entirely uprooted from their home environment do not require the long "settling-down" period before any treatment can take effect. Finally, it provides an opportunity for educating the mothers, many of whom come from primitive, peasant homes, in personal hygiene.

If the mother cannot come, an older sister or grandmother may be admitted. The system seems to be working to the benefit of the Tuzla hospital, child, and mother. —*News Bulletin of the International Hospital Federation.*

The husband was curious. "Why do you weep and sniffle at a movie over the imaginary woes of people you've never met?"

The wife replied, "The same reason why you scream and yell when a man you don't know slides into second base."—*Davis' Nursing Survey.*

The ASTRUP METHOD



. . . for **pH** *and Bicarbonate Determinations of Blood Samples*

RADIOMETER
ASTRUP APPARATUS

Blood pH can now serve a more useful clinical or research function with the new, Danish developed, Astrup apparatus — using as an indicator Radiometer's Model 22 PH meter.

Dr. Astrup's method provides for separate determinations of pH, pCO_2 and a resultant determination of bicarbonate concentration. The greatest merit in this method is its function of classifying and analyzing the anomalies of the acido-basic balance of the blood; and the speed and accuracy with which these determinations can be made.

The equipment provides combined glass-calomel electrodes built into the measuring chamber, with an enclosing jacket to provide temperature control by water thermostat.

Provision is also made for introducing the samples, buffers, etc., with ease and speed; as well as presenting CO_2 of known partial pressure for the pCO_2 determination.

Associated with this equipment, the Radiometer PH22 instrument, with a special, external type, mirror scale meter provides a direct reading accuracy as low as ± 0.01 pH, with high stability and low drift.

For interested research biochemists — further details are available.

IMPORTED AND SERVICED EXCLUSIVELY BY

Bach-Simpson
LIMITED

1255 Brydges St. London, Ontario

Sold in Canada by

CANADIAN LABORATORY SUPPLIES
TORONTO, MONTREAL, WINNIPEG, EDMONTON, OTTAWA

Consulting Services
(continued from page 56)

information about the quantities, types and nutrition adequacy of the food purchased.

They also confirm that patients and staff can be fed nutritious diets for less than 75 cents per meal day, for raw foods. This is the maximum amount allowed in determining Saskatchewan Hospital Service Plan rates of payment to Hospitals.

To conduct a survey, a visit is made to the hospital by a staff dietitian and an accountant. Invoices for each item purchased for each month are reviewed and analyzed as to *quantity* and *price*. Precautions are taken to ensure that all purchases are accounted for and the accuracy of the meal day count is verified. It is obvious that accurate record keeping is essential. During such a visit the dietitian has an opportunity to inspect and taste the food served.

The food purchases are classified according to the following groups: fresh meat, canned meat, fresh fish, canned fish, poultry, milk and cream, butter margarine, cheese, other fats, ice cream, eggs, milk powder, bread, cereal products, canned fruit, fresh fruit, canned vegetables, fresh vegetables, sugar, other sweets, coffee and tea, prepared products such as cake mixes, canned soups and miscellaneous items.

The next step is to determine, by individual items, the total *quantities* of food purchased. The work up to this point provides the basis for calculating the amount and the cost of food per meal day. The nutritional adequacy of the diet provided is calculated from the analysis of the quantities of food purchased and compared with Canada's Food Rules. When the results of such a survey are compared with the food allowances recommended in Canada's Food Rules, it can be shown whether or not the essential food nutrients are being provided, with variety and without waste.

Finally, the percentage of the food dollar spent on individual and group items is calculated.

Recommendations to the hospital are then prepared and sent to the hospital board, the administrator of the hospital, and the supervisor of the dietary service.

Special Diet Manual.

The Saskatchewan Department of Public Health has developed its own *Special Diet Manual*. Prepared officially in loose leaf form, to permit revisions as necessary, it is dis-

tributed to all hospitals. The manual contains a special section on infant feeding.

Bulletins

Since 1956 a bulletin has been distributed to all hospital cooks each month. It contains information on nutrition, special diets, menu planning, standardized recipes, portion control, purchasing, sanitation, et cetera.

Schools for Hospital Cooks

During 1956, in collaboration with the Department of National Health and Welfare, a very successful two-week institute for hospital cooks was conducted. During 1957, two similar institutes were held. Sixty-one hospital cooks received certificates upon satisfactory completion of these courses.

Lectures were given on feeding children and older people; the nutritive value of dairy products, eggs, cereal products, fruit, vegetables and meat; menu planning; purchasing; meal day costs; safety; storage; refrigeration; work schedules; special diets; santitation; food service; tray setting and portion control. The students put into practice what they learned from the lectures, by planning menus based on Canada's Food Rules and adapting them for children, older people and special diets; figuring out the orders and costs for menus; and making work schedules for their own institutions.

A food preparation demonstration and a fish cookery demonstration were given at each school. Films such as "What We Eat, We Are", "Why Won't Tommy Eat?" and "Hospital Food Service Personnel Training" were shown. A panel, consisting of a sanitary officer, nursing consultant, and clinical laboratory consultant were called upon to answer many questions in respect to sanitation. Visits were made to a wholesale grocery, bakery and meat packing plant, as well as to a 500-bed hospital and a 100-bed geriatric centre.

Did You Speak?

Some speakers are prone to mistake the external graces of distinction for distinctness, but what they do not realize is that distinctness of speech in itself confers distinction. "Speak out" should be the watchword of all, whether his speech be public or conversational. It means a steadily maintained *projection* of the voice, proportioned to the requirements of the immediate circumstances. — *The Hearing Eye.*

Classified Advertising

Senior Assistant Dietitian

Excellent opportunity to work in Ontario's newest and finest Dietary Department. 500 bed hospital: 44 hour week. Four weeks' annual vacation. General sick leave benefits. Pension scheme. 3-4years' experience preferred. Salary commensurate with administrative qualifications. Our need is urgent! Please apply to: Director of Dietetics, Brantford General Hospital, Brantford, Ontario.

Administrator Wanted

Administrator wanted for 77 bed general hospital. Please state qualifications, references and salary expected. Box 295L, The Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario.

Wanted—Staff Dietitian, C.D.A.

For 450-bed general hospital with training school. Excellent personnel policies, liberal salary and vacation, 40-hour week. Superannuation plan. Apply to Director of Dietetics, Royal Jubilee Hospital, Victoria, B.C.

Chief X-Ray Technician

An immediate vacancy exists in a 480 bed hospital for this position. Experienced in teaching students an advantage. Apply giving full details of experience, qualifications and salary expected to: Personnel Officer, Royal Columbian Hospital, New Westminster, B.C.

Canada's Chemical Valley

Sarnia, Ontario

Director of Nursing Services

Required for modern 300 bed, well equipped general hospital. This progressive industrial city of 45,000 is growing; it is a summer resort area located on the shores of Lake Huron and St. Clair River.

This fully approved hospital (JCAH) has approved schools for nurses, laboratory technologists, X-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a bachelor's degree in Administration, and successful experience in the field of Nursing Education as well as in Nursing Administration. For more details and literature concerning the position and Sarnia, write to Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

Operating Room Supervisor

for

Saint John General Hospital,
Saint John, N.B.

400 bed hospital

with

School of Nursing — 150 students.

Qualifications: post - graduate certification in operating room technique and management with experience.

Apply to

Director of Nursing,
Saint John General Hospital,
Saint John, N.B.

Colgate's ENCORE

the ideal hospital soap for these 3 reasons

MILDNESS! *PURITY!* *ECONOMY!*

MILDNESS—Encore's rich, abundant lather cleanses thoroughly, yet rinses easily. Even the tender skin of a new-born infant is as safe in Encore as in water alone. *No soap is milder!*

PURITY—Because Colgate uses only the highest quality ingredients, and adds no "extra" ingredients, Encore Soap meets the highest hospital standards for purity.

ECONOMY—Encore is "hard-milled"—all excess moisture is squeezed out. That's why Encore *noticeably* lasts longer. And yet Encore costs not a penny more than the soap you're now using.

ENCORE—Manufactured and packaged in 4 oz., 2 oz. and 1 oz. sizes especially to meet hospital needs. Every cake is backed by Colgate's unconditional guarantee.

OTHER GUARANTEED COLGATE PRODUCTS FOR HOSPITAL USE

GOLDEN XXX CHIPS OR POWDER

For your hospital laundry Golden XXX is the finest soap manufactured. Economical and pure.

ARCTIC SYNTEX

End 90% of Hand Dishwashing Work! For completely clean-sanitary dishes and glassware use Arctic Syntex.

AJAX

Famous "Foaming Action" cleanser that polishes as it cleans. Removes soap film—gets porcelain and enamel spotlessly clean. Now packed in 48, 14 oz. tins per case and in 150 lb. drums.

COLGATE-PALMOLIVE LIMITED

Nursing Assistant Course at High School Level

In London, Ontario, an experimental program to help meet the nursing shortage is being carried out at high school level. The Co-operative Course for Nursing Assistants, as the newly instituted pilot project is called, is being conducted jointly by the Departments of Education and Health in the Beal Technical and Commercial High School. It began last September and will continue for a three-year period throughout which evaluation and assessment will be done.

The Nursing Assistant curriculum is integrated with Grades XI and XII. Students carry their regular academic subjects along with nursing subjects, and on completion of Grade XII will possess the title of Certified Nursing Assistant as well as a secondary school diploma. In-service experience is received at the Victoria Hospital, London, Ont., under the direction of nurse instructor Eileen Healey. Miss Healey is a member of the high school staff and is responsible for the nursing content of the course which is inspected by the Nursing Branch.

Early in the planning, this program was discussed with the Registered Nurses' Association of Ontario to assure that the diploma issued would be considered as meeting the minimum requirements for admision to schools of nursing in the province.

Although it is conceivable that girls completing this course may discover an interest in nursing, hitherto unrealized, and wish to enter training to become a registered nurse, the new course has been established primarily for the student who would not be interested in the three-year regular program.

Blackfeet Generous Blood Donors

Last summer more than sixty Indians of the Blackfoot Reserve at Gleichen, Alta., donated blood to the Red Cross. It was an expression of the tribe's gratitude for transfusions received. One woman donating blood said she had received 13 transfusions; many others had had two or more.

As one donor, Joe Bear Robe, put it: "Indians get hurt too and they also need operations; so they like to do their share in supporting the blood donor clinic". Joe Bear Robe has been a regular donor at Red Cross clinics in Gleichen since 1951 and was honoured for his service by being presented with a Five-Year Donor Pin.

The clinic, believed the first to be held on an Indian reservation, was held mainly to re-stock blood banks in Indian hospitals in Alberta, but the blood can be used anywhere. Blood from Indian donors has been instrumental in the past in saving lives, many of non-Indians.—*Indian News.*

To Share Views

Central Supply Room Supervisors of Greater Winnipeg have formed a group as a means of exchanging ideas, standardizing Central Supply Room methods, and of exchanging literature related to their work. The members are from all hospitals in Winnipeg and the Winnipeg Clinic. Their meetings are held the last Tuesday of each month, alternating between the hospitals. As well as featuring speakers, the group plans to have films. Through this group many methods have already been standardized.

JOHNSON PNEUMATIC CONTROL—*IT PAYS!*

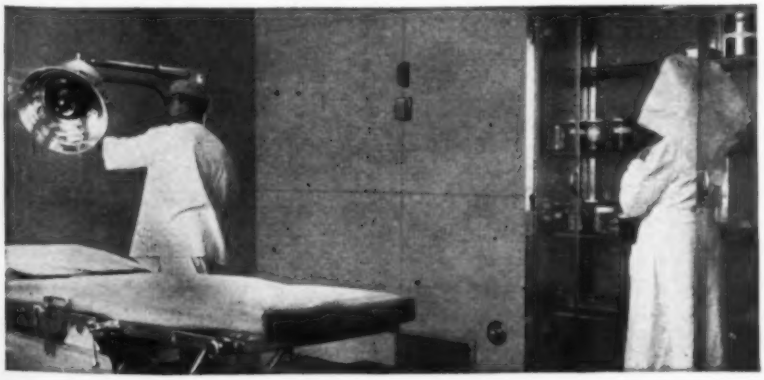
One of Canada's best equipped new hospitals is the new Colonel Belcher Hospital. Occupying a full city block in Calgary, it has a capacity of 396 beds. Special facilities include departments of physio therapy and remedial exercises, prosthetic services, occupational therapy, arts and crafts.

To maintain the proper thermal conditions for patient care and comfort and to minimize operating expenses, a Johnson Pneumatic Control System was installed for the regulation of air conditioning, heating and ventilating systems. The operating floor has the extra protection of Johnson Humidity Control.

The specialist Johnson organization offers you unmatched advantages for the all-important job of effective temperature control. Only a pneumatic control system can meet the many varied temperature and humidity requirements of the modern hospital and do it so simply, safely and economically.

Pneumatic control is far easier, less costly to operate, offers complete flexibility to meet every need. It's safe under all conditions—*even in the presence of explosive gases.* Upkeep is less—pneumatic control components outlast all other types. And only pneumatic control can be used effectively with all types of heating and cooling systems. It makes your operation virtually waste-free!

To provide the best possible thermal environment when you build or modernize, be sure your control system is by Johnson, the leader in pneumatic control. A nearby Johnson engineer will welcome the opportunity to discuss with you, your engineer or architect the control system best suited to your needs. Johnson Controls Ltd., Toronto 16, Ontario. Direct Branch Offices in Principal Cities across Canada.



* *Colonel Belcher Hospital, Calgary, Alberta. Rule, Wynn & Rule, architects; Angus, Butler & Associates, mechanical engineers; Poole Construction, general contractor; Canadian Comstock Co., mechanical contractor; all of Calgary.*

JOHNSON CONTROL
PNEUMATIC SYSTEMS
GROWING WITH CANADA SINCE 1912

. . . Across the Desk

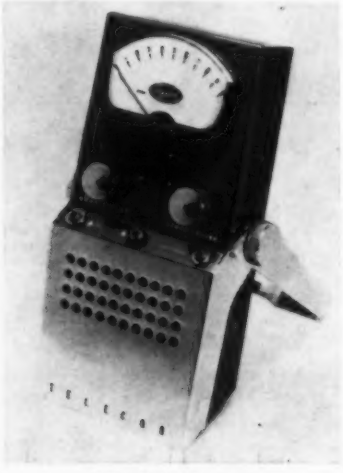
News Released by Hospital Supply Houses

By C.A.E.

Burdick Introduces New Cardiac Monitor

The Burdick Corporation, Milton, Wisconsin, has released to the market a new, versatile cardiac monitor. Called the Burdick Telecor, this compact unit provides continuous audible and visual indication of the heart rate and rhythm.

Telecor has many advantages destined to make it a popular item in the medical and hospital fields. Undoubtedly its outstanding advantage is that it has both an audio and visual heart signal indication. Its tone can be heard by the entire surgical team or an earphone can be attached to allow it to be heard by one member only. The swinging needle indicator, however, makes it easily visible to everyone.



Burdick Telecor

The Telecor can be conveniently placed in the operating room, recovery room, or by the bedside of the cardiac patient. It is made of anodized aluminum and has a functional design that allows it to stand by itself or hang from the anaesthesia — or plasma-administering equipment. Another advantage is that the Telecor is pocket-sized and weighs less than two pounds, with a power supply of only 3 volts. It operates on two long-life batteries.

The complete unit includes earphone, 2 cords with electrodes and straps, tube electrode paste, carrying case, 2 needle adapters and two spare batteries.

The Burdick Corporation is this year observing its 45th year of service and research in the medical field.

New Kodak Medical X-Ray Film Reduces Exposure Time

A new medical x-ray film which substantially reduces exposure times needed in making radiographs has been introduced by Canadian Kodak Co., Limited.

Named "Kodak Royal Blue Medical X-Ray Film", it has been tested extensively in hospitals and radiologists' offices.

Development of the new medical film follows the introduction in 1955 by Kodak of an improved dental x-ray film which has drastically reduced exposure times needed in dental radiography.

The new medical film is described by Kodak officials as having "much greater" sensivity than the company's well-known and presently available Blue Brand Medical X-Ray Film.

It is expected that radiologists will on the average find that they can reduce exposures to approximately one half those now being used.

Stryker Electro-Surgical Unit Has New Attachments

Three new attachments have been developed for use with the Stryker Electro-Surgical Unit. The contra-angle attachment, the sagittal plane saw attachment and the pencil-grip rotary hand piece attachment round out the unit.

The contra angle handpiece is designed to reach difficult locations at right angles to the point of access. The sagittal plane saw utilizes the oscillating method of cutting. Blades for the new saw operate from the end of a narrow arm and can be interchanged without special tools. The saw is designed to reach narrow, deep locations where visability is difficult. The pencil-grip rotary handpiece attachment is a re-designed burring and drilling tool which increases visability in reaching deep narrow locations. It is ideal for grafting, cleaning out scars, taking off cartilage, cleaning out areas of chronic bone infection and trethining the skull.

Hospitals presently in possession of this Stryker Electro-Surgical Unit can further increase the versatility of this instrument with the addition of these three new attachments. For complete details contact Fisher & Burpe Limited, at any one of their offices.

New Stryker Unit

(continued on page 114)

Across the Desk

(continued from page 112)

Sterile Packaged Catheters Now Available

Pre-packaged and pre-sterilized Bardex Foley Catheters, ready for instant use without processing or autoclaving, are now being distributed by C. R. Bard, Inc., Summit, New Jersey. Hermetically sealed in a transparent plastic enclosure and sterilized to conform to USP-UX standards, the package is said to be extremely durable, with a shelf life of up to two years ensured by the maker.

The new package has been thoroughly tested and approved by a group of 31 hospitals over a six-month period, and has already been adopted for use by many leading institutions.

Among the advantages cited by the maker is ease of opening and removal of the catheter, with sterility maintained, and simplified inventory control for Central Supply because these catheters require no processing or autoclaving. Elimination of processing time and labour costs results in substantial saving for the hospital, Bard reports.

The new package affords a special convenience to the physician, for his house calls or office use. Literature on request.

Dixie Cup Company Addition To Brampton Plant

Dixie Cup Company (Canada) Limited, has announced an addition to its Brampton plant and office which will increase existing facilities by approximately fifty per cent.

T. D. Currie, Vice President and Secretary of the Company, said work on the new addition has begun and that completion is scheduled for August 1, 1958.

The new facilities will total 43,200 square feet. Of that amount 38,400 square feet will be devoted to manufacturing and 4,800 to office accommodations. The addition will be directly east of the existing structure.

Dixie moved to Brampton from Toronto in 1949. The Brampton plant was almost doubled in 1952. The new addition, therefore, means that by next year the Brampton facilities will be approximately three times their original size.

Carl Schroder of Radiometer, Copenhagen, Visits Here

A recent visitor to Canada and the United States was Mr. Carl Schroder of Radiometer, Copenhagen, Denmark, manufacturers of electronic and electrochemical laboratory instruments. During his stay he visited with the representatives of Radiometer—Welwyn International Inc. of Cleveland; Bach-Simpson Limited in London; and Canadian Laboratory Supplies Limited, Toronto.

Carl Schroder

Oxygen Masks Should be Stored Properly

Positive-pressure and meter-type oxygen masks should be stored in complete units, assembled in accordance with the manufacturer's instructions. In both these masks the rubber tubing provided by the manufacturer must be used for effective therapy. If tubing of different length or lumen is substituted, the concentration of oxygen actually delivered to the patient will differ from that shown on the meter.

Although the inspiratory valve, bag, tubing, and concentration meter of these two masks are interchangeable, the face pieces are quite different. The face piece of the positive-pressure mask has wide flanges to insure a leak-proof fit. This is necessary for the control of the prescribed pressure on exhalation.

If the various parts of these masks are stored loosely with other apparatus, it is quite possible that someone unfamiliar with the apparatus could assemble a mask incorrectly. The results would be ineffective treatment for the patient who used it. When each mask is properly assembled and stored in a plastic bag, such errors will be eliminated.

From "Linde Oxygen Therapy Bulletin", published by Linde Air Product Company, Toronto 7.

New Castle Steam Sterilizer Design Introduced

A new series of pressure steam sterilizers has been introduced by Wilmot Castle Company, Rochester, New York.

The new series, which has been designated the "Straightline Series", was developed in an attempt to furnish maximum chamber capacity per unit cost. The square shape of the chamber is adapted particularly well to the rectangular shape of most hospital packs. It is equally suited to prepacked boxes of instruments, and glass containers can also be processed with minimum waste of chamber space.

The Straightline design has been incorporated into the Castle Dressing Sterilizers, Infant Formula Sterilizers, Hi-Speed Instrument Sterilizers, and the Laboratory Autoclaves. Units can be furnished with either steam or electric heat-

(concluded on page 116)

Across the Desk
(concluded from page 114)

ing and both recessed and cabinet mounted models are available.

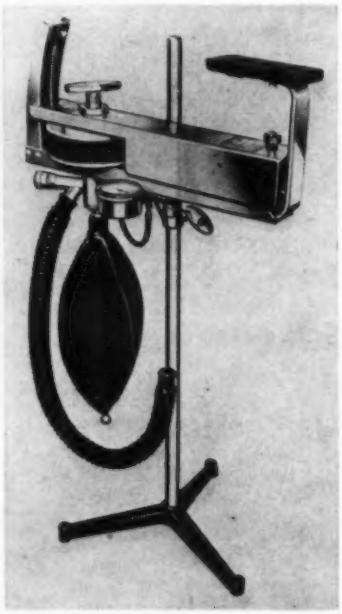
The new series incorporates all of the exclusive Castle features that are standard on the company's cylindrical models. These features include: a full steam jacket which surrounds the chamber on all sides as well as the backhead area, providing faster heating and better drying; and a dual-lock door which provides a mechanical lock as well as an automatic pressure lock to prevent the possibility of opening the chamber door while under steam pressure.

The Infant Formula Sterilizer is available in either single or double wall models. The chamber size is 20″ x 20″ x 36″. Two shelves and 24 racks provide space for 192 bottles.

Further information on the Straightline Series may be obtained by writing to Wilmot Castle Company, Rochester 3, New York.

The Etsten Ventilator Used in Circulatory Operation

A delicate circulatory operation was performed at the New England Center Hospital last September and reported in the September 26 edition of the *Boston Evening American*. Diagnosed as an aneurysm of the ascending aorta, it had to be removed and the artery sutured.

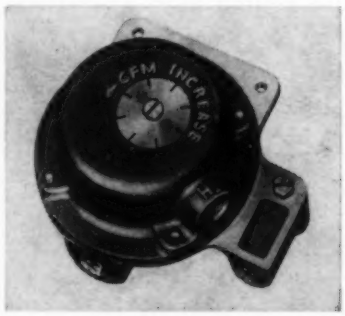


The patient was put into a state of hypothermia in which his temperature was lowered to 87 degrees. His complete breathing function was taken over for 18 hours using the Etsten Ventilator, operated by its originator, Dr. Benjamin E. Etsten, head of the Department of Anaesthesia, assisted by Dr. John H. Hopika. The successful operation was performed by surgeons Dr. Harold F. Rheinlander and Dr. Allan D. Callow.

Full information available from Ohio Chemical & Surgical Equipment Company, (A Division of Air Reduction Company, Inc.), Madison 10, Wisconsin.

Johnson Develops New Control For Air Conditioning Systems

A simple new control device that greatly increases the accuracy and reduces the cost of installing and operating the popular high velocity, double duct type of air conditioning system has been introduced by Johnson Controls Limited, Toronto.



With this new device, called the R-316 Air Flow Controller, each room in a building is supplied with a constant volume of conditioned air. The R-316 is installed in the thermostatically controlled high velocity units which mix hot and cold air in proper proportions to meet each room's temperature requirements. A change in the amount of hot or cold air delivered to one room no longer need upset the temperature or volume of air supplied to other rooms.

Johnson engineers say the R-316 assures constant volume air delivery to each room regardless of the number of mixing units in the system, the length of duct runs or differences in pressure between the hot and cold air ducts. The controller is designed for use with leading makes of mixing units.

Besides greatly increasing the accuracy and flexibility of room temperature control, the R-316 has important economic advantages. Large savings in initial fan costs, fan horsepower consumption and duct design are possible because, with the R-316, the air conditioning system can be designed to operate with minimum duct air pressures. Additional savings result from eliminating the need for costly and difficult manual balancing of the air conditioning system.

Complete information is contained in Bulletin M-104-6. Write Johnson Controls, Limited, Toronto 16, Ontario.

Wear-Ever Introduces Instantaneous Compress Steamer

The Fresh-o-Matic Compress Steamer eliminates wringing out hot compresses and scalding the hands. With the Fresh-o-Matic by Wear-Ever simply place the wet, cold compress in the unit, depress the lever two or three times and an instantaneously hot compress is ready for use.

There is no danger of the compress cooling while enroute to the patient. With the Fresh-o-Matic, compresses may be heated right at the patient's bedside if desirable, since the unit occupies only a little over a square foot of space, plugs into a standard 115 volt A.C. outlet, and can be placed on a wheeled cart.

The compress steamer offers convenience, speed and safety in the physiotherapy department and other treating areas in the hospital. Being a non-pressure unit with its own water supply (always use distilled water), there is no need for steam and water connections. Fresh-o-Matic is fully underwriter-approved, operates on 1400 watt 115 A.C. current, and measures 15″ wide, 11″ high, and 12″ deep.

Full particulars available from Aluminum Goods Limited, Toronto 3, Ont.

Nurse (to male ex-patient): "Why, Brown, I hardly knew you with your clothes on!"

Index of Advertisers

FEBRUARY, 1958

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.

When Staphylococcal infection threatens use the most sanitary blanket ever invented . . .

The Thermo-San* Blanket

*Reg'd. T.M. Patent Pending

Designed and engineered for hospital use

Sanitary — Can be washed in any soap or detergent. Can be boiled. Will not shrink, bunch or mat. Dries quickly to orginal texture.

Warmth — Laboratory tests have proved that the Thermo-San blanket provides equivalent warmth to two wool blankets yet insulates against heat in summer.

Light-Weight — A Thermo-San blanket weighs only 50% of a normal wool blanket. This feature has proved of great therapeutic value in arthritic cases.

Non Allergenic — Proved by exhaustive tests.

Breathability — Enough body moisture can evaporate to minimize perspiration build-up.

Non-Conductive — Static electricity will not accumulate in a Thermo-San blanket as it does in other materials. No fire hazard.

Moth Proof — As well as vermin proof.

Storage — Can be stored in half the space allotted for a woollen blanket.

Thermo-San
PRODUCTS LTD.

2090 West 41st Avenue, Vancouver, B.C.

V84-1

have CLEAN paper towels always handy!

So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

So sanitary—No handling soiled towels—no risk of infection. Brompton towels *touch no one's hands but those of the user.*

So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

So economical—Save money with *low cost* Brompton paper towels.

Brompton K-20—These general service Kraft towels have maximum absorbency and are recommended for general washroom use.

Brompton W-20—These white towels are unsurpassed in quality . . . are lint-free . . . soft . . . very absorbent . . . do not fall apart when wet. They can be used as industrial "white-wipes" to wash, polish or clean up anything.

Made in Canada by St. Lawrence Corporation Limited, Montreal, Que. Mills located at Dolbeau, East Angus and Three Rivers, Que., Nipigon and Red Rock, Ontario.

Wood's SANITATION FOR THE NATION

Exclusive Distributors

G. H. WOOD & COMPANY LIMITED

MONTREAL TORONTO VANCOUVER • BRANCHES THROUGHOUT CANADA